Doctorate in Clinical Psychology: Main Research Portfolio

1) Critical Review of the Literature: How well do voice-hearing assessment measures capture the positive experiences of individuals? A systematic review of published assessment measures; 2) Service Improvement Project: Mindfulness for mixed presentations across the lifespan: evaluating and improving the Mindful Life group using Thematic Analysis; 3) Main Research Project: Exploring factors that influence foster carer responsiveness to children: carer emotional distress, emotion regulation and placement arrangements.

Armstrong, Lucy

Award date:
2019

Awarding institution:
University of Bath

Research Portfolio Submitted in Part Fulfilment of the Requirements for the Degree of Doctorate in Clinical Psychology Volume 1 of 2

Lucy Armstrong

Doctorate in Clinical Psychology

University of Bath
Department of Psychology

May 2019

Declaration

I declare that the work presented in this portfolio is my own and has not been submitted for any other degrees in this or any other university or institute of learning.

Word counts

Critical Review of the Literature	6254
Service Improvement Project	5276
Main Research Project	5500
Executive Summary	583
Connecting Narrative	2972

Blank page

Table of contents

Table of Tables

Table of Figures

Critical Review of Literature

A large proportion of individuals hear positive voices or make positive interpretations about their voice-hearing (VH) experiences. However, current assessment tools may not capture positive aspects of VH as comprehensively as they capture negative aspects. This may limit accurate assessment and formulation of voices when people seek help from mental health services. **Aims:** To conduct a systematic review, answering the following question: How well do VH assessment measures capture positive experiences of individuals? **Method:** We identified 33 assessment measures which included at least one item on VH. We developed a novel framework to define "positive VH experiences", which was co-produced by clinical experts in psychosis and people with VH experiences. This framework was used to identify and map any items relating to positive aspects of VH. **Results:** Of the 33 measures identified, 20 incorporated positive VH experiences. We found that measures published within the last decade (2009-2019) captured a greater number and diversity of positive VH experiences, compared to measures published prior to 2009. Items relating to the *function/intention of voices* and the *emotional impact* of experiences, were most commonly found in measures. **Conclusions:** Results suggest a trend towards considering broader and more positive experiences of VH over time, and a growing view within research of VH as being on a spectrum with normal, healthy psychological functioning. **Clinical implications:** Utilising measures which include positive aspects of VH may provide clinicians with more holistic understandings of VH experiences; this in turn could influence treatment approaches and potentially enhance engagement amongst voice-hearers.

Keywords: voice-hearing, auditory hallucinations, systematic review, assessment measures

Service Improvement Project

Mindfulness-based group interventions (MBIs) are increasingly being offered by health services for a range of mental and physical health conditions. Despite the broad effectiveness of MBIs, most research has been conducted in specific conditions and age groups. The Mindful Life (ML) group is a 12-week introductory mindfulness course for people with varied conditions and ages, run by a UK secondary care mental health service. **Aims:** This project aimed to evaluate the ways in which the ML group benefits a mixed group of service users and how it could be further improved. **Method:** Semi-structured interviews were conducted with eight individuals who had attended the ML group within the last 18 months. Interviews were transcribed and a Thematic Analysis conducted. **Results:** Three overarching themes were formed: 1) being in a group, 2) how mindfulness is taught and learnt, and 3) making change for the good. Themes informed recommendations for improving the way future ML groups are structured and run. **Conclusions:** Most participants found the group beneficial in its current format due to the flexible and non-judgemental attitude of facilitators, the supportive group environment, and the range of practices covered. Suggested areas for improvement were increasing session structure, having longer practices, and increased prompting and support around barriers to home practice. **Clinical implications:** The project provides insights on how to develop the ML group under a new framework, for the benefit of future attendees. Findings and recommendations may offer guidance to other secondary services wishing to develop introductory MBIs for heterogenous patient groups.

Keywords: mindfulness, MBCT, group interventions, mixed group, improvement project, evaluation

Main Research Project

Background: Fostered children are highly vulnerable to developing emotional and behavioural difficulties, due to early adverse experiences they have often endured. Successful foster care placements can provide a safe base and an opportunity for developing secure attachments, which in turn can aid emotional recovery. Though we are aware that positive carer-child interactions are central to placement success and the longevity of carers in the profession, we know little about the factors that influence carer responsiveness to children. **Aims:** This study investigated whether carers' emotional distress, emotion regulation (ER) strategies, and their caregiver responsibilities (i.e., how many young people they care for) were associated with responsiveness to child distress. In addition, we explored whether ER is associated with carer distress (depression, anxiety and stress) in order to understand how these factors interrelate. **Method**: Eighty-six foster carers of children aged 4-12 years old, were recruited online and via posters to complete an online questionnaire battery about their emotional distress, ER strategies, caregiver response styles and various characteristics associated with care. **Results:** Carers with higher levels of distress (depression, anxiety and stress) were less likely to show supportive (emotional and problem-focused) responses. In addition, carers with more children to look after were less likely to encourage a distressed child to express themselves. Carer ER style was not significantly associated with carer mental health, nor with carer responsiveness. **Conclusion:** Findings suggest the importance of supporting carer well-being, both for the child and carers' benefit, and for the success of placements and the continued profession.

Keywords: foster care, emotion regulation, foster children, caregiver responsiveness, parenting practices

Blank page

How well do voice-hearing assessment measures capture the positive experiences of individuals? A systematic review of published assessment measures.

Lucy V. Armstrong

Department of Psychology, University of Bath

Lva21@bath.ac.uk

Academic supervisor: Dr Pamela Jacobsen

Word count: 6254

Target Journal: Schizophrenia Bulletin

Blank page

Introduction

The World Health Organisation (Sartorius, Shapiro, & Jablensky, 1973) outlines that auditory hallucinations, especially hearing voices, are amongst the most commonly observed symptoms in schizophrenia. Early diagnostic models conceptualised voice-hearing (VH) experiences as "first rank symptoms" of mental disorder, suggesting that individuals with such experiences would ultimately require treatment (Schneider, 1959). However, VH has also been identified in the general population as a relatively common occurrence (Johns et al., 2014), leading to a shift in considering VH as being on a spectrum of non-pathological experiences (Beavan, Read, & Cartwright, 2011). This has led to increasing popularity of the continuum model which postulates that VH experiences are positioned along a continuous dimension between non-voice-hearing individuals and clinical voice hearers, with “healthy-voice-hearers” reporting anomalous experiences but without a need for clinical care (Claridge, 1994; Claridge & Beech, 1995). This continuum view has received considerable research support (Linscott & van Os, 2013; Linscott & van Os, 2010; van Os & Reininghaus (2016).

Regardless of changing understandings, existing research and interventions still largely adopt the traditional view that VH indicates illness, distress and dysfunction (Bentall, 2004), overshadowing both “healthy” and positive VH experiences. This can be partially understood as a cultural stance towards voices as being “abnormal” and pathological within mainstream Western societies, and historical dominance of the medical model. In addition, most of the existing literature around VH has been conducted with patient groups (i.e. those who are help-seeking), leading to our understanding that many individuals aim to disengage from, suppress or avoid distressing voices (Turkington, Lebert, & Spencer, 2016).

A number of studies have demonstrated that beliefs and overall experiences of VH can be positive; much of these come from the healthy-voice-hearing literature. Researchers have shown that the lifetime prevalence of hearing useful and positive voices is around 40-60% in psychotic and non-psychotic populations (Jenner, Rutten, Beuckens, Boonstra, & Sytema, 2008), that 52% of patients report some positive effects of HV (Miller, O'Connor, & DiPasquale, 1993), and that around a third of patients even experience voices as pleasurable (Sanjuan, Gonzalez, Aguilar, Leal, & Van Os, 2004). Healthy-voice-hearing status has also been significantly predicted by

predominantly positive voice content (Daalman, Boks et al., 2011; Daalman, van Zandvoort et al., 2011). In addition, research conducted with participants from non-Western and non-mainstream subcultures (e.g., which value healers, shamans and mediums) has suggested a role for spirituality and religiosity within positive VH experiences. Though this research is sparse, researchers have found associations between VH experiences and feeling positively connected with higher powers (i.e. gods, spirits, djinns), as well as feeling or being seen as gifted or special (Boyd Ritsher, Lucksted, Otilingam, & Grajales, 2004; Jackson, Hayward, & Cooke, 2010; Luhrmann, Padmavati, Tharoor, & Osei, 2015; Stephen & Suryani, 2000).

Although at present there are no specific models of positive VH, a few prominent researchers have proposed that individual interpretation is central to how VH is generally experienced. Chadwick and Birchwood's (1994) cognitive model of auditory hallucinations established the notion that appraisals of VH mediate the relationship between experiences and the responses individuals have. Their research found that beliefs about voices' omnipotence and intention (whether malevolent or benevolent) influenced individual emotional and behavioural responses (e.g. engaged with voices, voice command compliance). Another model developed by Beavan (2011) aimed to define the key characteristics of VH by exploring the phenomenological experiences and beliefs of voice-hearers. Within this model, Beavan acknowledged that the following factors contributed to what could be considered positive VH experiences: the voice content is positive, the relationship with the voice is positive and the impact of VH is positive and enriching.

Further research has found that individual beliefs about VH affect whether individuals engage with services and whether they receive a clinical diagnosis (Johns et al., 2014). One possible reason for non-engagement with services and/or treatment is a concern about losing positive voices or those found to be useful in some way (Jenner et al., 2008). Non-compliance in taking medication within patient groups has also recently been understood in terms of the fear of losing benefits from positively perceived symptoms (Moritz, Andreou, Klingberg, Thoering, & Peters, 2013). These are important factors to consider, as individuals who do not engage with services, including those with positive experiences, may still have other difficulties with which they could benefit from support (de Leede-Smith & Barkus, 2013). To enhance patient engagement and offer tailored treatments, it is necessary for professionals to take a

broader, idiosyncratic stance when providing assessment for people who hear voices. This can then lead to formulations which accurately represent the experiences of individuals, including which aspects they would like to change, and which helpful or positive aspects they would want to maintain.

In terms of assessment tools there is a reliance on the use of self-report or interviewer measures to identify and understand VH experiences, which are otherwise private and not easily observed. Several researchers have looked at the psychometric properties of VH measures and commented on the ongoing development and growing diversity of the aspects captured by such scales. Of note are two systematic reviews which have been published 13 years apart; the first by Frederick and Killeen (1998), and a subsequent update review by Ratcliff, Farhall and Shawye (2011) who explored 10 additional measures that had been developed. The latter authors observed two patterns within more recently published measures: 1) a significant growth in measures capturing beliefs and interpretations of VH experiences, and 2) a greater number of measures (eight out of ten) which involved self-report. There has not yet been a consideration of positive aspects of VH within outcome measures.

Since this latter review, there has been an explosion within the hearing-voices movement alongside the rise of social media opportunities for discussing and promoting mental health awareness. Examples of significant moments within the last ten years include: VH activist Eleanor Longden's TED talk on The Voices in my Head (Longden, 2013), viewed over 4 million times, and a recently published paper "Understanding Psychosis and Schizophrenia" which commented on the commonality and acceptability of VH experiences around the globe (Cooke, 2017) .With this growing momentum in VH awareness, there has also been an increased impetus for research and clinical training schemes to take more qualitative and service-user-led approaches (Corstens, Longden, McCarthy-Jones, Waddingham, & Thomas, 2014). Amidst broadening perspectives there is reason to warrant a review of the research literature with regards to the way clinicians assess and capture positive aspects of VH.

The research question for this study was: How well do voice-hearing assessment measures capture the positive experiences of individuals?

Method

There were two main stages to the study: -

1) First, a systematic review identified all published VH measures for psychosis or psychotic-like experiences, including those that have been published in the last 9 years (since the last published review of Ratcliff et al., 2011).

2) A novel framework featuring categories of "positive experiences" of voice hearing was defined using a co-production model between expert clinicians and experts by experience, and by triangulating these views with the existing literature on VH experiences. Eligible VH measures were evaluated using a standard data extraction form, which incorporated the novel framework, to identify any items which related to positive experiences of voice hearing.

Stage 1: Systematic Review of VH measures

Protocol.

Methods, rationale, specified search terms, and items for data extraction were included in a research protocol, which was written before the searches were started. This was pre-registered on the Prospero database (https://www.crd.york.ac.uk/PROSPERO; registration number: CRD42019125554) on 15th February 2019, and the Open Science Framework (https://osf.io/hgjcn/) on 12th March 2019.

Eligibility Criteria.

Inclusion and exclusion criteria.

Inclusion: -

i) Any measures/tools for assessing VH experiences (Voices specific measures, OR any psychosis or psychotic-like experiences measure which includes voice items).

ii) Published between December 2009 (date of last searches from Ratcliff et al., 2011) and January 2019

iii) Papers from any country, provided that they were written in English, or an English-language translation was available

Exclusion: -

iv) Full-text of measure not available (individual items need to be identified for the purposes of identifying those which relate to positive experiences)

v) Translations of previously published measures (pre-2009), with no new content (added as exclusion criteria after commencement of searches)

Search methods and terms.

PUBMED/MEDLINE, PsycInfo and PsycTESTS were searched. Search terms were: voice-hear* (hearers, hearing), auditory hallucinations, instrument, measure, scale, interview (see Appendix 1b for full search string). Reference lists for full text articles were hand searched along with references on well-known voice-hearing websites (e.g. https://hearingthevoice.org). Authors were contacted if information needed to ascertain inclusion/exclusion was absent from published papers.

Measure selection and data extraction.

The titles and abstracts of all returned results were assessed by the primary reviewer (LA) according to the eligibility criteria. Full text papers were then independently assessed by the primary and secondary reviewer (PJ). It was at this stage that reviewers decided to apply an additional exclusion criterion (see above) as 8 out of the 22 papers featured pre-existing outcome measures which had been more recently translated to another language. Following this, reviewers agreed on inclusion/exclusion for 15 out of 22 measures (77% agreement rate). Where there were disagreements on reasons for exclusion, these were resolved in a joint meeting. The PRISMA flowchart (see Figure 1.1) outlines the process of identification, screening, eligibility and inclusion for all papers. Following PRISMA guidelines (Moher, Liberati, Tetzlaff, Altman, & Group (2009), reasons for exclusion were not collected or provided at title/abstract stage. However, the most common reasons for paper exclusions were non-relevance to voice-hearing/psychotic experiences and the lack of a developed outcome measure.

Data from the resulting papers were extracted by the primary reviewer, including study population and participant demographics, baseline characteristics,

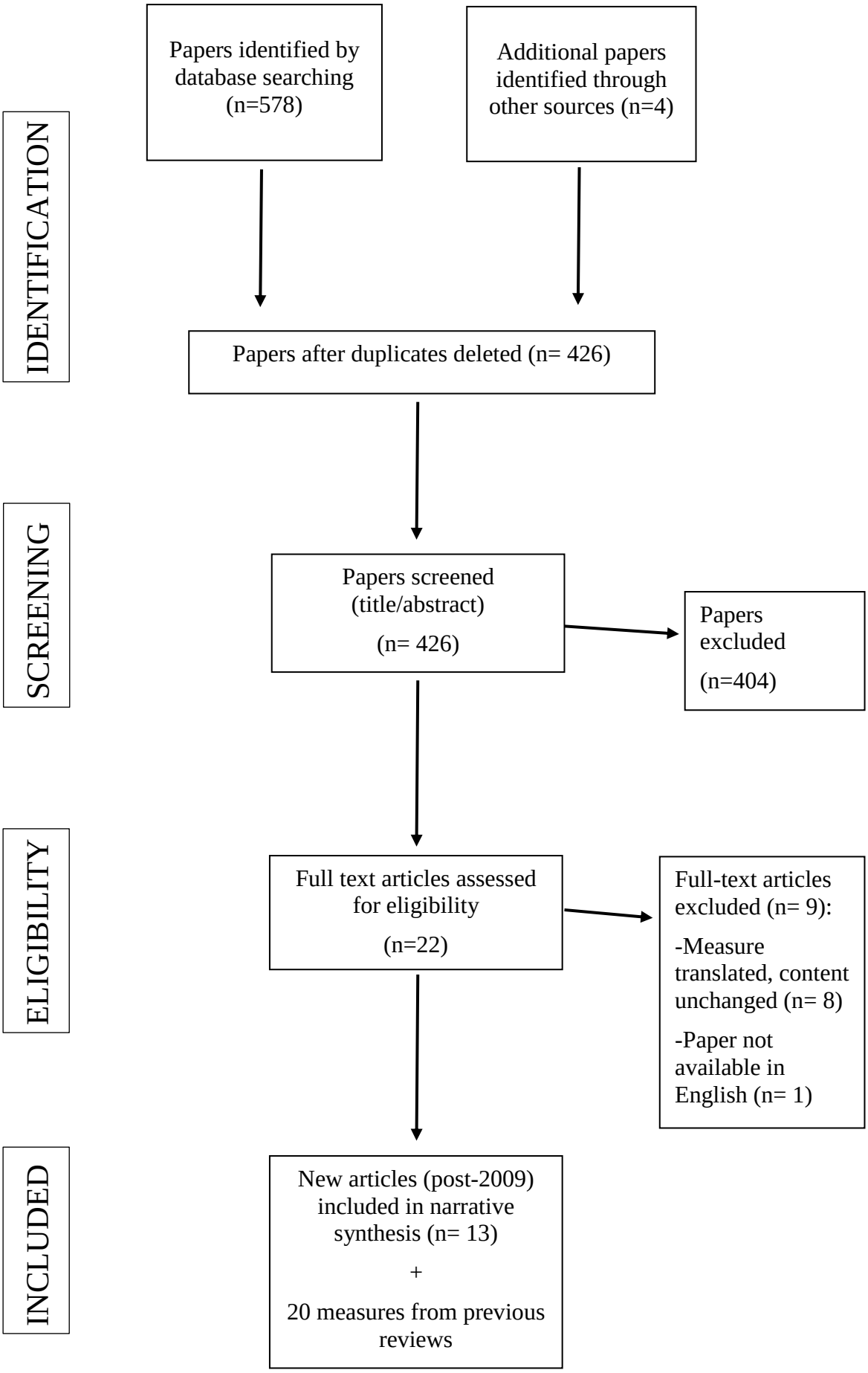


Figure 1.1 PRISMA flowchart of literature search (2009-2019)

information about measures (items, validity, reliability, what form it takes e.g. interview or self-report), whether service users/patients have been involved in the design of measures, aim of measure, and which positive categories have been captured (according to our developed framework). Extracted data tables were checked by the second reviewer.

Quality assessment.

Since the review was not aiming to investigate treatment effects or outcomes, no quality assessment tool was used. As part of data extraction, the psychometric information for included post-2009 measures (such as validity, reliability etc.) was recorded and reported in the results.

Phase 2: Developing and applying a framework for positive experiences of Voice-Hearing (VH)

The second part of this study was to assess whether published measures of VH captured aspects of positive VH experience. To do this, a framework was co-produced with a range of professionals and experts by experience. This framework consisted of categories of positive VH experience, based on a triangulation of clinical knowledge, expertise by experience, and information from the research literature on this subject. The following steps were taken to achieve this:

-A review of papers referring to "positive VH experiences" was conducted and key ideas were drawn from these. In addition to research texts, the Hearing Voices website forum was also reviewed for any themes around positive VH.

-These ideas were discussed with the project supervisor, which led to the development of three positive categories: 1) identity of voice, 2) relationship to voice and 3) beliefs about self as voice-hearer.

-Categories were discussed with a Peer Mentor from an Early Intervention (EI) service who also experienced their own voices. They suggested an additional positive category of "impact on life".

-A range of researchers and clinical professionals were approached and the four VH categories were discussed with them. Professionals included an expert psychosis clinician and researcher, two specialist Early Intervention (EI) Clinical Psychologists, two community psychiatrists (one affiliated with EI services and the Hearing Voices

Network, HVN), a nurse practitioner and two Social Workers from a secondary mental health service. These discussions led to the collapsing of two categories (identity of voice and relationship to voice) into one single dimension, and the consideration of two more categories: "behavioural response to voice" and "emotional impact of voice".

-Categories were reviewed by the primary reviewer and supervisor, and the decision was made to change the "behavioural response" category to capture "function/intention of voice" with the aim to enhance subjectivity of VH experiences rather than rely on objective views of behaviours.

-The resulting five categories were discussed with three experts by experience from the HVN, one of whom was the chair of a local South-West Hearing Voices group. The "impact on life" category was renamed as "meaning-making from VH experience" to better capture their personal experiences.

The final framework is detailed in the results section.

Next, the primary reviewer examined and rated items from each of the 33 measures in relation to the framework, and these were recorded in the data extraction form as either being "relevant" or "irrelevant" to each category. Only items that captured positive aspects of VH (rather than negative or neutral aspects e.g., pitch/loudness of voice) were recorded. The secondary reviewer independently reviewed the data extraction forms and rated positive items in the same way using the framework. Ratings were compared and reviewers agreed on the categorisation of 135 out of 151 positive items (89%). Discrepancies were discussed and consensus achieved, leading to a final recategorisation. One item was duplicated across two categories as it was felt to relate to both relationship/identity of voice and function/intention of voice.

Results

Stage one of this project involved providing an update of VH measures for psychosis or psychotic-like experiences that have been published in the last 9 years (since the last review). Thirteen assessment measures met the inclusion criteria (see Table 1.1). These were broad in their aims, from assessing phenomenological aspects of VH to rating experiences of psychotic symptoms more generally. Six measures outlined subclinical experiences related to voice-hearing (e.g. aspects of inner speech), and the same papers referred to measure development using non-clinical samples.

Table 1.1

Summary of statistics and reliabilities for measures December 2009 – February 2019

Reference	Country	Scale	No. items (subscales)	Participants	Internal consistency*	Reliability*
Alderson-Day et al., 2018	UK	VISQ-R	35 (5)	General pop. /students= 1566 adults,	α>.79 for all subscales, except "Positive"	-
Brockman et al., 2015	Australia	VAAS-9 and VAAS-12	9 and 12	SZ=40 adults	α>.8 for both VAAS-9 and VAAS-12	VAAS-12: r=.72-.82 (Shawyer et al., 2007)
de Chazeron et al., 2015	France	PSAS	89 (4)	PD=86, SZ=51	α=0.49 - 0.77 (lowest is for visual hallucinations)	Test-retest: Agreement % = 0.75 - 0.97 Inter-rater: Agreement % = 0.78 - 1.0
Gerlock et al., 2010	USA	UVS/ HCSP	UVS=7, HCSP=6	Scale not evaluated	-	-
Haddock et al., 2011	UK	SEPS	41 (3)	PSY=100 adults	α/ρ= .54-.95	ρ= .36-.83
Hodgekins et al., 2012	UK	SSI	20 (3)	Students= 808 adults, PSY =86 adults	α=0.87–0.92 for total, 0.72–0.90 for subscales	r=0.85 for total, 0.60–0.84 for subscales

Reference	Country	Scale	No. items (subscales)	Participants	Internal consistency*	Reliability*
Kelleher et al., 2011	Ireland	APSS	7	School adolescents =334	-	-
McCarthy-Jones & Fernyhough, 2011	UK	VISQ	18 (4)	Students/general pop. =235 adults	α= .80-.88	r=.61-80
Mitchell et al, 2017	Australia	MUSEQ	43 (6)	Student/general pop. =1268 adults, SCZ/BPD=32	α=.77- .88	r=.56-.77
Perona-Garcelán et al., 2015	Spain	DAIMON	28 (4)	Patients= 51	α=.0.80 - 0.84	r=.53-.78
Savitz et al., 2011	USA	PaSI	20	SCZ=8 adults	-	-
Schlier et al., 2017	Germany	CAHSA	12 (4)	General pop. =84	-	-
Trygstad et al., 2015	USA	AHIG	32	SCZ= 62	-	-

Note: - indicates that no information was found. *Figures are from original author papers. PSY=Psychosis/psychotic conditions, SZ=schizophrenia/schizoaffective/ schizophrenia spectrum disorder, PD=Parkinson's Disease, BPD=Bipolar Disorder. VISQ/R=Varieties of Inner Speech Questionnaire/Revised. VAAS=Voices Acceptance and Action Scale. PSAS=Psycho-Sensory hAllucinations Scale. UVS/HCSP=Unpleasant Voices Scale & Harm Command Safety Protocol. SEPS=Subjective Experiences of Psychosis Scale. SSI=Schizotypal Symptoms Inventory. APSS=Adolescent Psychotic-like Symptom Screener. MUSEQ=Multi-modality Unusual Sensory Experiences Questionnaire. PaSI=Panic and Schizophrenia Interview. CAHSA=Continuum of Auditory Hallucinations-State Assessment. AHIG=Auditory Hallucinations Interview Guide.

Positive experiences of VH Framework

Stage two of this study was to define what is meant by "positive experiences" of VH and to produce a framework from this, which could then be applied to published measures. Discussions with professionals and experts by experience resulted in the following categories by which to understand positive experiences of VH (see Table 1.2).

Table 1.2

Framework of Positive Experiences of Voice-Hearing

Category	Description
1. Relationship to voice	The relationship between individual and voice is inherently positive, *or* the voice represents a positive identity for the individual (e.g. protector, guide, companion, kind God/angel).
2. Beliefs/identity about self as voice-hearer	Individual identifies positively with being a "voice-hearer" *or* believes that hearing voices provides additional possibilities that are positive for them (e.g. being gifted, skilled, sensitive, balanced).
3. Function/intention of voice	The intention of the voice/s are viewed as positive (e.g. providing reminders, advice, encouragement) *or* the impact/function that voices have are positive for the individual.
4. Emotional impact of voice	The voice/s lead individuals to feel positive emotionally (e.g. calm, reassured, confident) *or* they reduce negative affect for the individual.
5. Meaning-making from VH experience	The individual attributes positive overall meaning from the presence of voices/ the experience of voice-hearing. This may include how the individual perceives their voice-hearing experiences in relation to their experience of life, well-being, or their connections with others.

Evaluating VH measures using framework of positive experience

Table 1.3 lists all 33 measures evaluated using this framework including 10 measures from the 1998 review, 10 measures from the 2010 review and 13 measures reviewed in this paper.

Table 1.3

Summary of all reviewed Voice-Hearing measures (in chronological order)

Publications	Scale	Assessment type	Service-user involvement mentioned? (Y/N)	At least 1 item capturing positive experiences? (Y/N)
Lowe, 1973	Phenomenologic characteristics of hallucinations.	Open-ended, unstructured interview	N	Y
Andreasen, 1983	SANS	Clinician rating	N	N
Andreasen, 1984	SAPS	Clinician rating	N	N
Junginger & Frame, 1985	Frequency and phenomenology of verbal hallucinations	Self-report	N	N
Kay, Fiszbein, & Opler, 1996	PANSS	Structured interview & observation ratings	N	N
Hustig & Hafner, 1990	Topography of voices rating scale	Self-report	N	Y
Miller, O'Conner, & DiPasquale 1993	Rating scale for phenomenology of hallucinations*	Semi-structured interview	N	Y
Carter, Mackinnon, Howard, Zeegers, & Copolov, 1995	MUPS	Semi-structured interview	N	Y
Chadwick & Birchwood, 1995	BAVQ	Self-report	N	Y
Oulis, Mavreas, Mamounas, & Stefanis 1995	Clinical characteristics of auditory hallucinations*	Open-ended, semi-structured interview & structured questions	N	Y
Haddock, McCarron, Tarrier, & Faragher 1999	PSYRATS-AH	Structured interview	N	Y

Publications	Scale	Assessment type	Service-user involvement mentioned? (Y/N)	At least 1 item capturing positive experiences? (Y/N)
Birchwood, Meaden, Trower, Gilbert, & Plaistow, 2000	VPD	Self-report	N	Y
Chadwick, Lees, & Birchwood 2000	BAVQ-R	Self-report	N	Y
Trygstad et al., 2002	CAHQ	Self-report	N	Y
Hoffman et al., 2005	AHRS*	Structured interview	N	N
Mann, & Pakenham, 2006	RAHQ	Self-report	Y	Y
Chadwick, Barnbrook, & Newman-Taylor 2007	SMVQ	Self-report	N	N
Shawyer, Ratcliff, Mackinnon, Farhall, Hayes, & Copolov, 2007	VAAS	Self-report	Y	Y
Van Lieshout & Goldberg, 2007	HPSVQ	Self-report	N	N
Hayward, Denney, Vaughan, & Fowler, 2008	VAY	Self-report	N	Y
Gerlock, Buccheri, Buffum, Trygstad, & Dowling 2010	UVS&HCSP	Self-report/ clinician protocol	N	Y
Haddock et al., 2011	SEPS	Self-report	Y	Y
Kelleher, Harley, Murtagh, & Cannon, 2011	APSS	Self-report	N	N
McCarthy-Jones, & Fernyhough, 2011	VISQ	Self-report	N	N
Savitz, Kahn, McGovern, & Kahn 2011	PaSI	Structured interview	N	N
Hodgekins et al., 2012	SSI	Self-report	N	N
de Chazeron et al., 2015	PSAS	Structured interview/ Clinician ratings	N	Y
Brockman, Kiernan, & Murrell, 2015	VAAS-9 and VAAS-12	Self-report	N	Y

Publications	Scale	Assessment type	Service-user involvement mentioned? (Y/N)	At least 1 item capturing positive experiences? (Y/N)
Perona-Garcelán et al., 2015	DAIMON†	Self-report	N	Y
Trygstad, Buccheri, Buffum, Ju, & Dowling, 2015	AHIG		N	Y
Mitchell et al., 2017	MUSEQ	Self-report	N	N
Schlier, Hennig, & Lincoln, 2017	CAHSA	Self-report	N	N
Alderson-Day, Mitrenga, Wilkinson, McCarthy-Jones, & Fernyhough, 2018	VISQ-R	Self-report	N	Y

Note: *Scale items not available, results are estimations based on measure descriptions or "sample" items. †Paper validated in Spanish, English items provided by authors (English validation study in press). SANS=Scale for Assessment of Negative Symptoms. SAPS=Scale for Assessment of Positive Symptoms. PANSS=Positive and Negative Syndrome Scale. MUPS=Mental Health Research Institute Unusual Perceptions Schedule. BAVQ/R= Beliefs About Voices Questionnaire/Revised. PSYRATS-AH= Psychotic Symptom Rating Scales-Auditory Hallucinations. VPD=Voice Power Differential. CAHQ=Characteristics of Auditory Hallucinations Questionnaire. AHRS=Auditory Hallucinations Rating Scale. RAHQ=Responses to Auditory Hallucinations Questionnaire. SMVQ= Southampton Mindfulness of Voices Questionnaire. VAAS=Voices Acceptance and Action Scale. HPSVQ=Hamilton Program for Schizophrenia Voices Questionnaire. VAY=Voice and You Scale. UVS/HCSP=Unpleasant Voices Scale & Harm Command Safety Protocol. SEPS=Subjective Experiences of Psychosis Scale. APSS=Adolescent Psychotic-like Symptom Screener. VISQ/R=Varieties of Inner Speech Questionnaire/Revised. PaSI=Panic and Schizophrenia Interview. SSI=Schizotypal Symptoms Inventory. PSAS=Psycho-Sensory hAllucinations Scale. VAAS=Voices Acceptance and Action Scale. AHIG=Auditory Hallucinations Interview Guide. MUSEQ=Multi-modality Unusual Sensory Experiences Questionnaire. CAHSA=Continuum of Auditory Hallucinations-State Assessment.

Descriptive data regarding pre-2009 measures has not been provided here, as this has been covered by previous authors. For some measures (those marked with *) it was not possible to access a list of scale items, despite attempts to contact original authors, therefore data in table 1.3 are based on measure descriptions and "sample items". Service-user involvement was recorded if specifically mentioned as part of scale development, with three papers meeting this description.

Positive experiences in VH items.

We found that the majority of measures did contain at least one item relating to positive aspects of voice-hearing (20/33; 61%), with the remainder not having any positive items at all (13/33; 39%). Out of the twenty measures with at least one positive item, seven of these included only one positive item. Eight measures included five or more items which related to positive experiences, and for one measure, the Subjective Experience of Psychosis Scale (SEPS; Haddock et al., 2011), most items referenced positive experiences. A table showing the number of scale items within each positive category of VH is provided in the Appendix 1d. One item, which asked a two-part question (AHIG; Trygstad, Buccheri, Buffum, Ju, & Dowling, 2015, q.4) was found to relate to more than one category, therefore this was duplicated for the purposes of understanding how categories had been captured.

Measures published in the last decade (2009-2019) were found to incorporate 48 positive VH items (49 including replicated items from revised measures, across seven measures). Measures published during the previous decade (1999-2009) incorporated 14 positive items (24 with replicated items, across eight measures). Finally, measures published prior to two decades ago (1973-1999) incorporated 30 positive items (across seven measures). Measures from the past decade accounted for the highest number of items in the following categories: *intention/function of voice*, *emotional impact of voice*, and *meaning-making from VH experiences*. Measures in the previous decade included the highest number of items in the *relationship to voice* category. Four items relating to *beliefs/identity about self as voice-hearer* were captured by measures published in 1993, 1995 and 2011. Results pertaining to each specific domain of positive experience are described below.

Relationship to voices.

Twenty items referenced positive relationships with voices or perceptions about the voice/s as holding a positive identity for the voice-hearer, thus mapping onto this category. Five items included questions about the companionship or closeness between voice and voice-hearer (e.g. "Does the voice keep you company when you're lonely?", Rating scale for phenomenology of hallucinations, (Miller et al., 1993, q.5). Two items asked about feeling encouraged and inspired by voices (e.g. "I have a tendency to look up to my voice", VAY; Hayward, Denney, Vaughan, & Fowler, 2008, q.6). One measure (DAIMON; Perona-Garcelán et al., 2015, included items that referenced positive ways in which voices spoke about people (e.g. "The voices talk to each other, [saying] nice things about me or the people in my environment", q. 23) and how voice-hearers in turn communicate positively back to them, for example "When I speak or converse with the voice, I tell it things that are amusing and funny" (q. 7).

Ten items related to the controllability of voices, with questions regarding the degree in which voice-hearers feel strong, powerful and in control in relation to their voices. As some items directly linked control and benefit for the voice-hearer (e.g. "The subject believes that he/she can control the voices and make them appear or disappear when he/she wants" (PSAS; de Chazeron et al., 2015, Item 31. Option 1) we decided to include all control related items under this category. The VPD (Birchwood, Meaden, Trower, Gilbert, & Plaistow, 2000) contributed the largest number of items to this category (six), with all pertaining to control, power and confidence between voice/s and voice-hearer.

Beliefs/identity about self as voice-hearer.

This category was the least represented by measures, with only four items pertaining to the positive beliefs or interpretations that voice-hearers held about themselves. Two of these items were included in the SEPS (Haddock et al., 2011) and referenced how VH experiences had positively impacted "personality/character" (q. 8) and "sense of personal identity" (q. 28). Other items referenced whether voices were aiding the individual to develop "special powers or abilities" (BAVQ/R; Chadwick & Birchwood, 1995; Chadwick, Lees, & Birchwood, 2000, q.8/11), and asked how voice-

hearers feel about themselves in comparison to others, offering “special” as a suggestion (Rating Scale for Phenomenology of Hallucinations, Miller et al., 1993, q.4).

Function/intention of voices.

The highest number of positive items (29) were categorised in terms of perceived intention of the voice and the impact or function of VH for the individual. Included in this category were perceptions of voices as encouraging, pleasant and friendly (e.g. “In your last illness episode in which you heard the voices, would you say the tone of the predominant voice(s) was generally: (ratings include "gentle", "loving", "kind" and "friendly")?”, MUPS; Carter, Mackinnon, Howard, Zeegers, & Copolov, 1995, q.12). In addition to clinical, hallucination-type voices, this category also included inner-speech items from the VISQ-R (Alderson-Day, Mitrenga, Wilkinson, McCarthy-Jones, & Fernyhough, 2018) which detailed ways in which individuals speak to themselves internally (e.g. “I talk to myself silently in an encouraging way”, p.19). Thirteen items asked whether voices are helpful (e.g. “I talk with the voices or listen to what they are saying – they may be helpful”, RAHQ; Mann & Pakenham, 2006, q.18), or if they have a positive impact on the individual’s performance.

Questions about aspects of performance enhanced by voices or VH included concentration, thought control, memory, socialising, finding work (all SEPS; Haddock et al., 2011, q.1, 14, 17, 19, 21), ability to work and sexual activity (Rating scale for phenomenology of hallucinations; Miller et al., 1993, q.8, 11), and decision-making (VAY, Hayward et al., 2008; q.2). Five items referenced voices and VH as having a healthy impact on individuals in terms of their sleep, energy, diet and capacity for self-care (e.g. Positive impact on “ability to look after yourself”, SEPS; Haddock et al., 2011) , q.6). Lastly, two items questioned the frequency in which voices were entertaining (e.g. “The voices talk to each other about topics that interest me and I want to be informed”, DAIMON; Perona-Garcelán et al., 2015), p.25), and two items enquired about the protectiveness of the voice (e.g. “My voice wants to protect me”, BAVQ/R; Chadwick & Birchwood, 1995; Chadwick et al., 2000, q.4/5).

Emotional impact of voice.

Twenty-six items enquired about positive emotional impact of voices and VH. These included feeling calm and reassured (eight items), for example "During the last 24 hours, how is the tone of your "voices"? (ratings include "moderately comforting" and "very comforting"; CAHQ; Trygstad et al., 2002, q.5). Again, inner speech items were included in this category, for example "I calm myself down by talking silently to myself" (VISQ-R; Alderson-Day et al., 2018, q.27). Five items referenced feelings of happiness, excitement, and "ability to enjoy hobbies and/or activities" (SEPS; Haddock et al., 2011, q.11), three items feelings of empowerment and one item asked about positive impact of voices on emotional connectedness (i.e. "ability to feel emotion", SEPS; Haddock et al., 2011, q.26). Reduction of negative affect was captured in nine additional items (eight of which were in the SEPS), and included positive impact on "levels of anxiety and stress" (q.4), "feelings of isolation" (q.12), "Feelings of vulnerability" (q.27), "Concerns about becoming unwell" (q.13) and being able to "easily change topics in my mind and talk to myself about other things" when feeling upset (VISQ-R; Alderson-Day et al., 2018, q.35).

Meaning-making from VH experience.

This category refers to items which capture wider positive beliefs about VH experiences and could be broken down into *connection to others* (three items) and *outlook* (nine remaining items). Eight of these overall items were listed in the SEPS measure (Haddock et al., 2011), and included questions about how VH has positively impacted individuals' "feelings of discrimination or being judged" (q. 25) and "ability to trust others" (q.2). Items related to positive outlook referenced future-oriented thinking in relation to voices, for example "My voice is helping me to achieve my goal in life" (BAVQ/R; Chadwick & Birchwood, 1995; Chadwick et al., 2000, q. 10/14), and whether voices had a positive impact on "Hope for the future" (SEPS; Haddock et al., 2011, q. 7).

Three items questioned positive overall stances on VH, including whether the individual would continue experiencing voices (Rating scale for phenomenology of hallucinations, (Miller et al., 1993, q.1), whether they were "grateful for my voice" (BAVQ/R; Chadwick & Birchwood, 1995; Chadwick et al., 2000, q.12/17), and a general question, "How much have you viewed having your experiences as positive?" (SEPS;

Haddock et al., 2011, q.40). Lastly, one item asked an open-ended question regarding the overall meaning of VH, which could suggest a meaningful outlook, "Is it possible that the idea behind the message/content of the voices is linked or connected to someone who is or was influential in your life?" (MUPS; Carter et al., 1995, q.23b).

Discussion

This study reviewed 33 measures of VH, including 13 published since 2009, assessing how well these captured positive experiences based on a developed framework (see Table 1.2). Results showed more than two-thirds of measures captured some element/s of positive VH. Findings suggest an increased trend over time for investigating positive aspects of VH, particularly relating to *intention/function of voice*, *emotional impact of voice*, and *meaning-making from VH experiences*. Findings also suggest a growing development of assessment tools capturing hallucination-type experiences in clinical *and* non-clinical populations. Trends are discussed below.

Trend toward broader "positive" perspectives

The current review could suggest a broadening perspective within the VH literature, that is the way voices are assessed in research and clinical practice. The current study found that measures published in the past 10 years (2009-2019) captured a higher number of positive VH items, compared with the preceding decades. This demonstrates the complexities of VH perceptions, and the need for broad and/or idiosyncratic means of assessment. It also suggests that capturing positive elements of VH should be viewed as relevant and important when it comes to assessing a person's *whole* experience, not just the distressing parts or "symptoms" as previous medical models (e.g. Schneider, 1959) have suggested doing. This applies also to open-ended questionnaires about inner experiences, as they aim to capture any and all experiences that individuals have, without leading them to answer on specific characteristics.

Types of positive experiences captured by measures

Overall, the positive categories most represented by items were *intention/function of voice* and *emotional impact of voice*. These categories included items relating to the helpful, entertaining and encouraging nature of voices, along with emotional consequences of VH

including feeling comforted, empowered and less negative. This finding supports the concepts of emotional and behavioural responses to VH which were detailed in Chadwick & Birchwood's cognitive model (1994). Although we have reconceptualised "behavioural response" as "intention/function of voice", our findings still highlight the important reciprocal links between beliefs about voices and the functional and emotional impact of them. "Emotional impact" is also one of five categories described in Beavan's (2011) model of essential characteristics of VH, suggesting how central this is to whether VH experiences are labelled as positive or negative. Research in this area has similarly focused on experiences of helpful, pleasant and positive aspects of VH, which have been reported by one third to over 60% of voice-hearers (Jenner et al., 2008; Miller et al., 1993; Sanjuan et al., 2004). The most recent of these studies (Jenner et al., 2008) found that "protective power", for both clinical and non-clinical groups, was the biggest reason voices were viewed as positive. This factor was something that most clinicians in the current study had observed in their work.

Relationship to voices was the next biggest category of positive VH, with the highest number of items captured by scales published in 1999-2000. This is unsurprising given the emergence of measures around this time that were designed to focus on beliefs, relationships and power dynamics related to voices (BAVQ; Chadwick & Birchwood, 1995, VAY; Hayward et al., 2008, VPD; Birchwood et al., 2000). This category incorporated several aspects of controllability (i.e. individuals having more control/power than their voices), which are also described in the cognitive model of VH (Chadwick & Birchwood, 1994). Controllability has been associated with lower likelihood of complying with command hallucinations (Trower et al., 2004), and a higher likelihood of voices being viewed as pleasurable (Sanjuan et al., 2004). Items in this category also referenced companionship and comfort from voices, which were similarly captured within the "relationships with voices" category of Beavan's (2011) model of essential characteristics of hearing voices. Lastly, positive communication and engagement with voices was captured within this category, which research has linked with being an important aspect of coping with VH experiences (Andrew, Gray, & Snowden, 2008).

Positive categories least represented by measures were *Beliefs/identity about self as voice-hearer* and *Meaning-making from VH experience.* Regarding the former, there

was little to suggest a growing research interest in this area. Similarly, other models of VH (Beavan, 2011; Chadwick & Birchwood, 1994) do not specifically explore this aspect in detail, rather incorporating ideas about self as part of the "emotional impact" of hearing voices). This lack of specific focus may suggest a couple of things: firstly, that positive beliefs about oneself as a voice-hearer may unfortunately be captured instead by delusion items within broader measures (e.g. "Do you have special and unusual powers or knowledge/ capabilities?", MUPS Delusions section, (Carter et al., 1995, q.5) and secondly, that Western-centric outcome measures (and thinking) may result in fewer positive interpretations about the self in relation to VH. Although many other cultures associate VH with spirituality and enlightenment, little of this is conceptualised in mainstream research and practice in the West (McCarthy-Jones, Waegeli, & Watkins, 2013). This represents not only a missed opportunity to assess VH beliefs in relation to other cultural understandings, but also limits the reach of practice.

The *Meaning-making* category incorporates the more powerful and overarching positive impacts of VH, which our experts by experience felt most strongly about when working on development of the framework for this review. Similarly, Beavan incorporated ideas about the enriching and positive impact of VH within her 2011 model, although these ideas were categorised in a different way to ours (i.e., under "emotional impact" of experiences). Well-established researchers such as Romme and Escher (1989) have linked attained meanings of VH experiences with greater ability to cope, therefore future measures could benefit from including aspects of meaning related to experiences. The SEPS, published in 2011 (Haddock et al., 2011), incorporated most items in this category, suggesting this could be a growing theme within VH research. Interestingly, the SEPS was generated by service-users, demonstrating the importance of involving individuals with personal experience when developing items of value and relevance.

Trend towards VH as seen on a continuum

This review erred towards inclusivity regarding assessments developed with non-clinical populations and pertaining to "subthreshold" symptoms and "psychotic-like" experiences. For example, the inclusion of measures which investigated "inner speech" (Alderson-Day et al., 2018; McCarthy-Jones & Fernyhough, 2011) was a deliberate decision by reviewers

to ensure no false divides were created between internal and externally-located voices. Although less is known about similar measures published prior to these (as will be discussed later), it is interesting that nearly half of the recent measures in this review referenced subclinical auditory hallucinations. It could be hypothesised that this broadening of "symptom" descriptions supports the larger cultural shift towards understanding voice-hearing as common and existing on a spectrum of experience, in line with the continuum model of VH (Claridge, 1994; Claridge & Beech, 1995). Some authors also suggest that assessing subclinical experiences increases understanding around predispositions to developing clinical-level symptoms (Kelleher, Harley, Murtagh, & Cannon, 2011), and for those in recovery, residual experiences and/or risk of relapse (Hodgekins et al., 2012).

Strengths and Limitations

This review effectively adds to the literature around positive experiences of VH, focusing on the role of outcome measures to capture these qualities. As part of this research, 13 measures, published since the last review in 2010, have also been evaluated. In selecting this topic, we were responding to reported figures that show a large proportion of individuals hear positive voices (see Jenner et al., 2008) and make positive interpretations of their VH experiences (Haddock et al., 2011). This topic has not been reviewed in this way until now. Unlike previous reviews, we chose to include dimensional measures of VH and subclinical auditory hallucinations. This provides a more nuanced picture of experience and focuses away from the view of VH as purely clinical and pathological, in keeping with increasing "hallucination spectrum" understandings. Another great strength of the current paper is the inclusion of a framework which has effectively operationalised "positive experiences" of VH. Importantly, voice-hearers were involved in the development of this framework, which has resulted in the categories and rich descriptions that are given. This approach is in line with suggestions of Corstens and colleagues (2014), that voice-hearers should be involved in identifying and measuring important domains of outcome which can then be prioritised for intervention research. This paper has identified the core domains that

voice-hearers link to positive VH experiences, and we can use this to direct and develop future outcome measures.

In terms of limitations, a number of measures which pertain to voice-hearing or psychotic-like experiences may not have been captured by this review, as they were published prior to December 2009. These were not accounted for in previous reviews for a couple of possible reasons. Firstly, search terms used by previous authors may not have included the same key words used by some publications. For example, the Positive and Useful Voices Inquiry (PUVI; Jenner et al., 2008) used the word "inquiry" rather than "instrument", "scale" or "measure" which were defined in the search terms by Ratcliff and colleagues (2011). This is unfortunate for the current review as the PUVI directly assesses the characteristics of positive (and useful) voices. It may be suggested that future authors ensure that key words be attached to their abstracts, so that papers can be identified by reviewers.

Secondly, as the search terms used in the current study were different to those used in the two previous reviews, this has led to the omission of some measures published prior to December 2009. Previous reviewers limited their searches to include measures that had only been developed and tested with adult clinical/patient populations. As a result, these measures were likely designed to captured more distressed and/or dysfunctional experiences relating to VH, and therefore fewer positive aspects of VH, affecting overall results for this review. In addition, measures developed with broader participant age ranges, such as the Auditory Vocal Hallucinations Rating Scale (AVHRS; Jenner & Van de Willige, 2002), developed with adults *and* adolescents, were also omitted from the current review. Neither of the previous reviewers included a search string, nor details of papers which were excluded from their final list, which makes it difficult to replicate their searches or understand which additional measures exist. These steps are recommended for future reviewers to make methodology as transparent as possible.

In addition to the above limitations, there is a possibility that papers detailing outcome measures may have been missed by having only one reviewer at title/abstract stage. Stoll and colleagues (2019) recently found that an additional 6.6 - 9.1% of eligible

studies were identified at this stage by using two reviewers. Future researchers could take account of the numbers above and consider the benefits of a second reviewer.

A final limitation surrounds the subjective process of assigning scale items to positive framework categories. For example, the VAY (Hayward et al., 2008) is described as a measure of "negative relating" to voices, however we considered two items of the *dependency* subscale as relevant to positive perceptions from the voice-hearer's perspective, as these may lead individuals to want continued VH experiences. Other researchers may choose to organise and categorise items differently, in accordance with available models and theories. To be transparent about these subjective processes, a table of categorised item is provided in Appendix 1c.

Clinical implications and future directions

This review highlights the need to assess broader aspects of VH, including the positive impact that experiences can have, to voice-hearers both within and external to services. This may include questions about how VH impacts identity and sense of self, and how individuals make meaning of their experiences. These could be in the form of open-ended interviews or structured self-report measures, so long as a balanced inquiry is made into the nuanced experiences of the individual.

In addition, though the aim of the current study was not to assess the psychometric properties of VH and psychosis measures, future outcomes measures should also strive to be reliable and valid for voice-hearing populations, in addition to capturing content that feels relevant and important. Indeed, a measure such as the SEPS (Haddock et al., 2011) demonstrated poor test-retest reliability across some items, however the approach taken to construct the measure (i.e., designed by voice-hearers and enquiring equally about positive and negative VH experiences) could be considered valuable for future development of related measures.

In light of the review limitations, we must be cautious about simply concluding that positive VH experiences are not well captured by existing outcome measures. Based on the measures we have included, the number of items relating to positive VH experiences do appear to be outweighed by those which are neutral or negative in nature. However, current reviewers could have taken a more robust approach by conducted

broader literature searches with no date limitation, effectively re-reviewing the literature independently. This was unfortunately beyond the remit for this review, however further research could seek to achieve this, which would contribute to our understanding of overall measures of VH experiences, from a more inclusive, dimensional perspective.

From a clinical perspective, VH measures which enquire about a range of experiences (including positive) should be used in more mainstream services, and professionals should continue to collect feedback about the relevance of these to service-users. Taking these approaches could encourage engagement from voice-hearers who may not otherwise connect with services and could help professionals understand motivations behind treatment non-compliance, adapting their approach accordingly. In addition, querying self and social identity in relation to voices may further our understanding of voice-hearing from non-Western perspectives, bridging the gulf between services and communities.

Conclusion

This review demonstrates the increasing stance that VH exists on a continuum and shows a trend towards considering the broader and positive experiences of voice-hearers. The review found that two-thirds of VH and psychosis measures referenced some aspect of positive VH experience, with *function/intention of voices* and *emotional impact* being the most represented categories of the developed framework. However, a thorough review of VH measures is warranted, to include earlier papers which may have not been captured in previous reviews, particularly those which include sub-clinical VH experiences and non-clinical samples. Furthermore, researchers should consider developing and/or improving existing outcome measures which assess positive VH experiences. Their clinical usage may have a significant impact on service-user engagement and treatment delivery in mental health services, and voice-hearers should have a central position in informing these future developments.

References

Alderson-Day, B., Mitrenga, K., Wilkinson, S., McCarthy-Jones, S., & Fernyhough, C. (2018). The varieties of inner speech questionnaire–revised (VISQ-R): replicating and refining links between inner speech and psychopathology. *Consciousness and cognition, 65*, 48-58.

Andrew, E. M., Gray, N. S., & Snowden, R. J. (2008). The relationship between trauma and beliefs about hearing voices: a study of psychiatric and non-psychiatric voice hearers. In *Psychol Med, 38*(10), 1409-1417).

Beavan, V., Read, J., & Cartwright, C. (2011). The prevalence of voice-hearers in the general population: a literature review. *Journal of Mental Health, 20*(3), 281-292.

Bentall, R. P. (2004). *Madness explained: Psychosis and human nature*. UK: Penguin.

Birchwood, M., Meaden, A., Trower, P., Gilbert, P., & Plaistow, J. (2000). The power and omnipotence of voices: subordination and entrapment by voices and significant others. *Psychol Med, 30*(2), 337-344.

Ritsher, J. B., Lucksted, A., Otilingam, P. G., & Grajales, M. (2004). Hearing voices: Explanations and implications. *Psychiatric Rehabilitation Journal, 27*(3), 219.

Carter, D. M., Mackinnon, A., Howard, S., Zeegers, T., & Copolov, D. L. (1995). The development and reliability of the Mental Health Research Institute Unusual Perceptions Schedule (MUPS): an instrument to record auditory hallucinatory experience. In *Schizophr Res, 16*(2), 157-165).

Chadwick, P., & Birchwood, M. (1994). The omnipotence of voices: A cognitive approach to auditory hallucinations. *The British Journal of Psychiatry, 164*(2), 190-201.

Chadwick, P., & Birchwood, M. (1995). The omnipotence of voices. II: The Beliefs About Voices Questionnaire (BAVQ). In *Br J Psychiatry*, *166*(6), 773-776.

Chadwick, P., Lees, S., & Birchwood, M. (2000). The revised Beliefs About Voices Questionnaire (BAVQ-R). *The British Journal of Psychiatry, 177*(3), 229-232.

Claridge, G. (1994). Single indicator of risk for schizophrenia: Probable fact or likely myth? *Schizophrenia Bulletin, 20*, 151–168.

Claridge, G., & Beech, T. (1995). Fully and quasi-dimensional constructions of schizotypy. In A. Raine, T. Lencz, & S. A. Mednick (Eds.), *Schizotypal personality* (pp. 192–216). New York: Cambridge University Press.

Cooke, A. (2017). *Understanding psychosis and schizophrenia: why people sometimes hear voices, believe things that others find strange, or appear out of touch with reality, and what can help*. UK: British Psychological Society, Division of Clinical Psychology.

Corstens, D., Longden, E., McCarthy-Jones, S., Waddingham, R., & Thomas, N. (2014). Emerging perspectives from the hearing voices movement: implications for research and practice. *Schizophrenia Bulletin, 40,* S285-294.

Daalman, K., Boks, M. P. M., Diederen, K. M. J., De Weijer, A. D., Blom, J. D., Kahn, R. S., & Sommer, I. E. C. (2011). The same or different? A phenomenological comparison of auditory verbal hallucinations in healthy and psychotic individuals. *Journal of Clinical Psychiatry, 72*(3), 320–325.

Daalman, K., van Zandvoort, M., Bootsman, F., Boks, M., Kahn, R., & Sommer, I. (2011). Auditory verbal hallucinations and cognitive functioning in healthy individuals. *Schizophrenia Research, 132*(2–3), 203–207.

de Chazeron, I., Pereira, B., Chereau-Boudet, I., Brousse, G., Misdrahi, D., Fénelon, G., . . . Marques, A. (2015). Validation of a Psycho-Sensory hAllucinations Scale (PSAS) in schizophrenia and Parkinson's disease. *Schizophrenia research, 161*(2-3), 269-276.

de Leede-Smith, S., & Barkus, E. (2013). A comprehensive review of auditory verbal hallucinations: lifetime prevalence, correlates and mechanisms in healthy and clinical individuals. *Front Hum Neurosci, 7*, 367. doi: 10.3389/fnhum.2013.00367.

Frederick, J. A., & Killeen, M. R. (1998). Instruments for assessment of auditory hallucinations. *Archives of Psychiatric Nursing, 12*(5), 255-263.

Haddock, G., Wood, L., Watts, R., Dunn, G., Morrison, A. P., & Price, J. (2011). The Subjective Experiences of Psychosis Scale (SEPS): psychometric evaluation of a scale to assess outcome in psychosis. *Schizophrenia research, 133*(1-3), 244-249.

Hayward, M., Denney, J., Vaughan, S., & Fowler, D. (2008). The voice and you: development and psychometric evaluation of a measure of relationships with voices. *Clin Psychol Psychother, 15*(1), 45-52.

Hodgekins, J., Coker, S., Freeman, D., Ray-Glover, K., Bebbington, P., Garety, P., . . . Fowler, D. (2012). Assessing levels of subthreshold psychotic symptoms in the recovery phase: the Schizotypal Symptoms Inventory (SSI). *Journal of Experimental Psychopathology, 3*(4), 582-593.

Jackson, L. J., Hayward, M., & Cooke, A. (2011). Developing positive relationships with voices: A preliminary grounded theory. *International Journal of Social Psychiatry, 57*(5), 487-495.

Jenner, J., Rutten, S., Beuckens, J., Boonstra, N., & Sytema, S. (2008). Positive and useful auditory vocal hallucinations: prevalence, characteristics, attributions, and implications for treatment. *Acta Psychiatrica Scandinavica, 118*(3), 238-245.

Jenner, J. A., & Van de Willige, G. (2002). *The auditory vocal hallucination rating scale (AVHRS)*. Groningen: University Medical Center Groningen, University Center for Psychiatry, University of Groningen.

Johns, L. C., Kompus, K., Connell, M., Humpston, C., Lincoln, T. M., Longden, E., . . . Cella, M. (2014). Auditory verbal hallucinations in persons with and without a need for care. *Schizophrenia bulletin, 40*, S255-S264.

Kelleher, I., Harley, M., Murtagh, A., & Cannon, M. (2011). Are screening instruments valid for psychotic-like experiences? A validation study of screening questions for psychotic-like experiences using in-depth clinical interview. *Schizophrenia Bulletin, 37*(2), 362-369.

Linscott, R. J., & van Os, J. (2010). Systematic reviews of categorical versus continuum models in psychosis: Evidence for discontinuous subpopulations underlying a psychometric continuum. Implications for DSM-V, DSM-VI, and DSM-VII. *Annual Review of Clinical Psychology, 6*(1), 391–419.

Linscott, R. J., & van Os, J. (2013). An updated and conservative systematic review and meta-analysis of epidemiological evidence on psychotic experiences in children and adults: On the pathway from proneness to persistence to dimensional expression across mental disorders. *Psychological Medicine, 43*(6), 1133–1149.

Luhrmann, T. M., Padmavati, R., Tharoor, H., & Osei, A. (2015). Hearing voices in different cultures: a social kindling hypothesis. *Topics in Cognitive Science, 7*(4), 646-663.

Longden, E. (2013, August). *The voices in my head* [Video file]. Retrieved from: https://www.ted.com/talks/eleanor_longden_the_voices_in_my_head?language=en

Mann, B., & Pakenham, K. I. (2006). Development of a measure to assess coping for auditory hallucinations. *Australian Journal of Psychology, 58*(2), 93-100.

McCarthy-Jones, S., & Fernyhough, C. (2011). The varieties of inner speech: Links between quality of inner speech and psychopathological variables in a sample of young adults. *Consciousness and cognition, 20*(4), 1586-1593.

McCarthy-Jones, S., Waegeli, A., & Watkins, J. (2013). Spirituality and hearing voices: considering the relation. *Psychosis, 5*(3), 247-258.

Miller, L. J., O'Connor, E., & DiPasquale, T. (1993). Patients' attitudes toward hallucinations. *American Journal of Psychiatry, 150*, 584-584.

Moher, D., Liberati, A., Tetzlaff, J., Altman, D. G., & Group, P. (2009). Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. *PLoS medicine, 6*(7), e1000097.

Moritz, S., Andreou, C., Klingberg, S., Thoering, T., & Peters, M. J. (2013). Assessment of subjective cognitive and emotional effects of antipsychotic drugs. Effect by defect? In *Neuropharmacology, 72*, 179-186.

Perona-Garcelán, S., Escudero-Pérez, S., Barros-Albarrán, M. D., León-Palacios, M. G., Úbeda-Gómez, J., García-Montes, J. M., . . . Pérez-Álvarez, M. (2015). Reliability and validity of a new scale for measuring relationships with voices: The DAIMON Scale. *Psychosis: Psychological, Social and Integrative Approaches, 7*(4), 312-323.

Ratcliff, K., Farhall, J., & Shawyer, F. (2011). Auditory hallucinations: a review of assessment tools. *Clinical Psychology & Psychotherapy, 18*(6), 524-534.

Romme, M. A., & Escher, A. D. (1989). Hearing voices. *Schizophria Bulletin, 15*(2), 209-216.

Sanjuan, J., Gonzalez, J., Aguilar, E., Leal, C., & Van Os, J. (2004). Pleasurable auditory hallucinations. *Acta Psychiatrica Scandinavica, 110*(4), 273-278.

Sartorius, N., Shapiro, R., & Jablensky, A., *1* (11), 21. (1973). The International Pilot Study of Schizophrenia. *Schizophrenia bulletin, 1*(11), 21-34.

Schneider, K. (1959). *Clinical psychopathology* (5th ed.). New York: Grune and Stratton.

Stephen, M., & Suryani, L. K. (2000). Shamanism, psychosis and autonomous imagination. *Culture, medicine and psychiatry, 24*(1), 5-38.

Stoll, C., Izadi, S., Fowler, S., Green, P., Suls, J., & Colditz, G. A. (2019). The Value of a Second Reviewer for Study Selection in Systematic Reviews. *Research synthesis methods.* DOI: 10.1002/jrsm.1369.

Trower, P., Birchwood, M., Meaden, A., Byrne, S., Nelson, A., & Ross, K. (2004). Cognitive therapy for command hallucinations: randomised controlled trial. *The British Journal of Psychiatry, 184*(4), 312-320.

Trygstad, L., Buccheri, R., Dowling, G., Zind, R., White, K., Griffin, J. J., . . . Covert, C. (2002). Behavioral management of persistent auditory hallucinations in schizophrenia: Outcomes from a 10-week course. . *Journal of the American Psychiatric Nurses Association, 8*(3), 84-91.

Trygstad, L. N., Buccheri, R. K., Buffum, M. D., Ju, D.-s., & Dowling, G. A. (2015). Auditory Hallucinations Interview Guide: Promoting recovery with an interactive assessment tool. *Journal of Psychosocial Nursing and Mental Health Services, 53*(1), 20-28.

Turkington, D., Lebert, L., & Spencer, H. (2016). Auditory hallucinations in schizophrenia: helping patients to develop effective coping strategies. *BJPsych Advances, 22*(6), 391-396.

van Os, J., & Reininghaus, U. (2016). Psychosis as a transdiagnostic and extended phenotype in the general population. *World Psychiatry, 15*, 118–124.

Blank page

Mindfulness for mixed presentations across the lifespan:

Evaluating and improving the Mindful Life group using Thematic Analysis

Lucy Armstrong, Department of Psychology
University of Bath
Lva21@bath.ac.uk

Academic supervisor: Dr Elizabeth Marks
Regional supervisors: Dr Helen Joannidi and Michael Houser

Word count: 5276

Target journal: This review will be submitted to *Mindfulness* (Springer US).

Blank page

Introduction

Mindfulness practice refers to the action of "paying attention in a particular way: on purpose, in the present moment, and non-judgementally" (Kabat-Zinn, 1994). The popularity of Mindfulness-Based Interventions (MBIs) such as MBCT (Mindfulness-Based Cognitive Therapy) and MBSR (Mindfulness-Based Stress Reduction) in health settings has grown significantly, in addition to the incorporation of mindfulness practices within other approaches (e.g. Dialectic Behaviour Therapy). MBIs have been shown to be effective in reducing symptoms in various mental and physical health conditions, and in enhancing quality of life (see Gotink et al., 2015) for a recent review).

A number of models have highlighted the mechanisms of action underlying the effectiveness of mindfulness techniques (Gu, Strauss, Bond, & Cavanagh, 2015). These include: decentering, attention regulation, exposure, nonattachment and nonaversion, self awareness and improved regulation, acceptance and compassion. Such mechanisms theoretically apply to a range of clinical difficulties, and evidence suggests that MBIs are effective in treating distress in conditions such as depression, fatigue, tinnitus, and somatising disorders (Lakhan & Schofield, 2013; Philippot, Nef, Clauw, de Romrée, & Segal, 2012; Strauss, Cavanagh, Oliver, & Pettman, 2014; Ulrichsen et al., 2016). Interventions such as MBCT attempt to achieve effects by enhancing practice with discussions, teaching on theory and encouraging reflections as homework.

Most research has been conducted with diagnosis-specific groups in clinical trials, although a few studies have tested MBIs in mixed groups. For example, Fledderus, Bohlmeijer, Smit, and Westerhof (2010) demonstrated the efficacy of a combined ACT (Acceptance and Commitment Therapy) and mindfulness intervention for improving well-being in participants with mild-to-moderate psychological distress. Although most studies focus on adults of working age, researchers have also demonstrated the value of MBIs in groups of older adults, finding reductions in blood pressure (Palta et al., 2012), back pain (Morone, Greco, & Weiner, 2008), and loneliness (Creswell et al., 2012). A recent systematic review (Gard, Hölzel, & Lazar, 2014) concluded that MBIs have the potential to offset cognitive decline and perhaps increase capabilities in older adults. Additionally, whilst research generally suggests that increased practice leads to increased benefits, evidence supports the use of even

very brief mindfulness interventions for conditions like pain (e.g. Zeidan et al., 2011), suggesting that these are still effective in reducing affective reactions and behavioural impulsivity.

Based on this research, it may be feasible and effective to provide integrated mindfulness groups that are conducted in a flexible way to suit the needs of individuals. This approach could improve accessibility to MBIs, and as a result, improve treatment efficiency and cost-effectiveness. It could also be relevant and useful to services that are increasingly moving towards 'lifespan' healthcare. Some UK services already offer MBIs in this way, for example in inpatient settings where flexibility and heterogenous groups have been found anecdotally to benefit a range of patients (Didonna, 2009). As services continue to adopt and adapt MBIs to suit heterogenous patient groups, it is critically important to carefully evaluate such interventions. This information will enable services to better understand changes and benefits reported by patients engaging in MBIs, and thus continue to improve service delivery.

The Service

A secondary mental health service in the South West UK adapted an 8-week MBCT (Segal, Williams, & Teasdale, 2002) to offer to a group of patients of mixed-age and mixed-presentations. Adaptations of this '*Mindful Life'* (ML) group included: extending the course duration from eight to 12 sessions, making sessions briefer (1 ¼ hours), and changing the session balance to involve longer discussions with fewer and shorter practices. These changes were made to suit clients whose difficulties were mostly current and chronic. Each week was themed based on elements of practice that are in line with the MBCT framework (e.g. "This the way it is", "Watching the thoughts"). The group was conducted three times per year and had been running since 2015, with approximately 8-9 people attending each group. Group members were referred in by four different services within the trust, including adult, older adult, psychosis, and memory services. Varied clinical presentations included depression, anxiety, personality disorders, psychosis, bipolar disorder, Mild Cognitive Impairment, physical health conditions (i.e. chronic pain, fatigue), and being a carer.

Aims

This project aimed to evaluate the way in which the *ML* group was delivered, with a view to providing recommendations for improvements. A specific focus was on evaluating the ML-specific adaptations around the balance between discussion and practice. Findings from this project were intended to help to shape future MBI groups in the Trust. Following initial consultation with the two group facilitators, and taking account of feedback forms from previous ML groups, the following four research questions were identified:

1) How do the participants of the *Mindful Life* group feel changes from the intervention occurred?
2) Have participants continued to practise and are they benefitting from the group once it has finished?
3) Which aspects of the intervention were most and least valued by participants?
4) How could the group be improved to encourage and enhance mindfulness practice for its members?

Method

The project was reviewed and approved by the University of Bath Psychology Ethics Committee (Project Reference 18-018) and subsequently approved by the Research and Development department at Avon & Wiltshire Partnership (AWP) NHS Foundation Trust (Reference E2018.002). See Appendix 2g for approvals. Participants provided written informed consent for interviews (see Appendix 2c and 2d). Two individuals from the service user involvement forum (one of whom had attended the ML group) consulted on the design of interview schedules, consent forms and recruitment approach.

Design

Research questions formed the basis of a series of semi-structured interviews (see Appendix 2e for interview schedule) with patients who had attended the ML group.

Participants and recruitment

Group facilitators invited previous group members to participate in interviews using a purposive sampling method, contacting individuals from the most recent ML groups first and continuing in reverse chronological order. Sampling aimed to recruit

a representative sample of participants, whilst aiming to gather data from more recent groups (for better memory recall).

Contact was made with 17 patients from the ML group, and 12 agreed to receive further contact from the researcher (Appendix 2a). Ten people (six working age, four older adults) were contacted (Appendix 2b) and gave consent to participate. Finally, eight people took part in interviews (two older adults dropped out due to illness and feeling too anxious). See Table 2.1 for participant demographic information.

Table 2.1

Participant information

Participant name*	Age	Self-reported difficulties	Service	Time since attending group
Mike	70	Carer of wife with severe and enduring mental health difficulties	Older adult	11 months
Shirley	52	Chronic pain, intrusive thoughts	Adult MH	7 months
Marcus	50	Chronic pain, anxiety	Adult MH	3 months
Phil	36	Chronic pain, anxiety, depression	Adult MH	11 months
Wendy	56	Difficulty managing emotions	Adult MH	8 months
Terry	71	Physical health issues, Difficult thoughts and memories,	Older adult	13 months
Emily	24	Chronic pain and fatigue, depression, anxiety	Adult MH	11 months
David	50	“Mentally ill”	Adult MH	3 months

* Names have been changed to protect anonymity. MH=Mental health

Procedure

Individual semi-structured interviews, lasting 20-30 minutes, were conducted over the phone with eight participants which allowed for reasonable coding opportunity and data saturation to be reached (Glaser & Strauss, 1967). To explore key themes there was a degree of prompting in interviews, particularly where participants struggled to

give descriptive detail. Participants were thanked for their time and debriefed (Appendix 2f).

Data analysis

Interviews were audio recorded, transcribed verbatim (using Express Scribe Transcription Software) and read twice through by the Principle Investigator (PI), LA, to ensure familiarisation. The PI then used a Thematic Analysis (TA) approach, following the suggested steps by Braun & Clarke (2006). The research questions were explorative and experiential in nature, so a contextualist framework for analysis was used. This assumed that language can provide access to truth, but that experiences and descriptions are socially mediated (Madill, Jordan, & Shirley, 2000). Two transcripts were initially coded, then checked by and discussed with the project supervisor (EM). A critical realist, inductive approach was taken, assuming that the words of the participants reflect their reality as closely as possible (Nightingale & Cromby, 1999), whilst allowing for interpretations from the researcher and participant. Once all transcripts were coded, the PI organised codes into initial themes and subthemes, which were discussed once again with the supervisor. Finally, themes and subthemes were reworked, ensuring that these were distinct and not overlapping. Less representative subthemes were discarded.

The Principle Investigator (PI) had a background interest in and experience of using MBIs both personally and professionally, as did the supervisor for the project. This positioning was reflected on when preparing the project proposal and may have informed discussions around analysis. Additionally, the PI reflected on her own positioning as a young, white, educated and middle-class female analysing data from a mainly male, middle-aged sample from a predominantly working-class area. It was important that codes and themes emerged from participants' own words and meanings, rather than these being imposed by researchers, however it has to be acknowledged that experience in MBIs likely brought a level of sensitivity to coding. For example, when considering participants' varied levels of connection with practice, researchers' own experience and commitment to mindfulness may have influenced the way these experiences were labelled. To enhance awareness of this an independent researcher with limited experience of MBIs coded one randomly selected transcript, and discrepancies were discussed and resolved with the PI. In addition, a log was kept to track the way in which themes developed and iterative

processes took place, and the PI made efforts to notice their own expectations and potential biases during analysis.

Results

Three overarching themes were categorised during the data analysis phase: 'Being in a group', 'How mindfulness is taught and learnt', and 'Making change for the good'. Themes and subthemes are summarised in Table 2.2.

Being in a group

This theme describes how participants related to being in a group, and how the therapeutic milieu affected mindfulness learning and practice. For most, the social atmosphere supported feelings of wellbeing, but two found it brought discomfort. The attitudes of facilitators and group members influenced participants' own approach to practice and the application of skills, and as such were crucial in facilitating change.

Atmosphere and tone.

Several participants reflected positively on the group atmosphere as safe and encouraging. They reported that the group facilitated a reflective space and aided focus, which in turn influenced their motivation to take practice home.

> "…It got you in the right frame of mind, so that when you left you felt more energised to do it for the next few days…[sessions] kind of like, recalibrate your brain…you're enthusiastic again" (David).

The group atmosphere was important, and the feeling of being playful, light and non-pressured allowed participants space to be themselves fully.

> "We had a laugh and a joke as well… it was very relaxed, and that was the important thing about it… there was nothing strict or regimented" (Mike).

Table 2.2

Themes and subthemes

Theme	Sub-themes
Being in a group	*Atmosphere and tone*: The mood of the group and attitudes of group members *Relating to others:* Connecting to and learning from other group members *Being in a group as unhelpful:* Discomfort in public sharing and burden/confrontation of hearing from other group members.
How mindfulness is taught and learnt	*Beliefs and approach to mindfulness:* Attitude, openness and expectations of self and practice. *Session format:* Practices used, structure of sessions and approach to teaching. *Commitment to practice:* Attitude towards home/continued practice and practical application to life.
Making change for the good	*A tool to manage difficulties:* Using attention to disengage from difficult experiences and focus on present moment. *A tool to connect and allow:* increasing awareness of experience, whether difficult or joyful, and building acceptance. *Compassion:* recognising own needs and developing kindness for others.

This aligned with participants' sense of facilitators as non-judgemental and flexible, which allowed freedom around practice. This was true even for those who struggled with aspects of the group environment.

> "They were really good… kind and understanding" (Phil).

> "There's no right or wrong" (Emily).

The attitudes of facilitators appeared to filter through to participants when they in turn recalled their approach to home practice (explored further in the *commitment to practice* section).

Relating to others.

Around half of the participants discussed how connecting with group members had provided a sense of a shared journey towards recovery and instilled a curiosity and recognition of potential practice benefits.

> "We just had that connection where we'd been in the same sort of zone, and we found that amazing 'cos we were both suffering from anxiety" (Marcus).

Other participants, including a carer, saw group relationships as important reminders of their connections to the wider world.

> "They are not alone with these problems…and, in my case…there are other people out there you can turn to and talk to" (Mike).

Group connection could also influence motivation to attend.

> "I felt part of that group, and it was a lovely group…I wanted to go" (Terry).

Participants found that learning from peers and not just from "seasoned professionals" provided a sense of group ownership and relevance. Three participants wanted more time to hear how other group members put practice into place.

> "It was more important for me to hear from my peers…about how they were getting on with [home practice]" (Marcus).

Group as unhelpful.

Though most participants appreciated the group environment, one participant reflected on her group as holding a more negative atmosphere.

> "I found it a very awkward group to be in… really dark and dreary… no interaction with people, hardly" (Wendy).

This alternative experience reflects how engagement with others in the group may affect acceptability, attendance and outcome. Being new to mindfulness, Wendy described being particularly self-conscious amid the lack of group connection, which meant she avoided sharing her experiences and later stopped attending.

Another participant felt burdened with hearing other people's difficulties and made excuses to avoid some sessions. Though he connected positively to mindfulness overall, he felt this was despite (and not because of) the group context.

> "I was struggling…I don't have the capacity to deal with other people's problems" (David).

Facilitators should be wary of the potential negative effects of a group setting for some individuals and consider ways to manage this.

How mindfulness is taught and learnt.

This theme describes the ways in which participants approached learning about mindfulness, including personal attitudes and expectations of practice. It also details how participants experienced teaching and practice both *within* the sessions, and how they applied it *outside* sessions and following the group.

Beliefs and approach to practice.

Participants' pre-existing attitudes and beliefs influenced their experiences of practice in three main ways. Three participants described an openness to the central concepts of mindfulness and a willingness when it came to practice. One of these individuals (ten years into her recovery journey), explained how her readiness to engage with 'acceptance' was shaped by her life experience.

> "At the stage I'm at in life, experience with being under the mental health service…[I have] actually been able to accept it very very quickly" (Emily).

Conversely, one participant described how fear of losing her usual coping methods had led her to avoid practice, despite "desperately" wanting to change.

> "I'm a very mechanical person…there's no feelings or emotions that go on in my life…I'm frightened of it…that was a block that was against the mindfulness group" (Wendy).

These different stories indicate how willingness to engage in mindfulness may depend on life stage, emotional state and readiness to change.

Secondly, participants' approaches were influenced by their expectations of practice demands. Five participants who reported difficulties with concentration saw this as a barrier, as they felt a particular mind state was a prerequisite for practice.

> "…It's very hard to do because my mind thinks a lot" (Phil).

> "[Need to be] in the right frame of mind" (Marcus).

Thirdly, beliefs about the impact of mindfulness influenced engagement and efforts. Hopefulness early on and a realistic sense that it would take time to observe benefits supported regular attendance and practice for two participants.

> "To be honest I wanted to get better, I wanted to feel better, so I found this…I wanted it to work for a start" (Shirley).

Most other participants needed time and evidence to draw conclusions about potential benefits of practice during the course, and this was seen as a learning process. This could occur following specific practices or come from an accumulation of observed progress. For example, one participant found a heartrate measurement application useful.

> "A reassurance that it was working, confirmation that it was doing something physical as well as mental" (Marcus).

Even those who found the group unhelpful still generally viewed mindfulness as a beneficial skill that required time to learn. With some remorse, and a sense of self-blame they believed that keeping up practice might have led to more change.

> "That's probably my fault, if I'd only kept up the sessions I would still be alright" (Phil).

Session format.

Participants were fully aware of various meditation exercises focusing on body, breath, senses, walking, eating, visualisations, and loving-kindness, and individuals found different practices particularly helpful. Four reported the body scan

to be most helpful, three of whom suffered with physical pain and used it in relation to their condition.

> "The body scan…all I could think about was the pain initially…but that improved" (Shirley).

Participants viewed short practices as a good way to "settle" into the room, however five wanted longer practices in the group, particularly at the end of sessions.

> "I preferred the slightly longer practices…they gave me a chance to really get into it and absorb it" (Marcus).

Six participants reported that facilitator-guided practices were easier than home practice.

> "You're being assisted to do it, you're not just on your own" (Emily).

Related to this, most participants recalled receiving weekly hand-outs and a few had used this at home, with one treating it as a "feedback" diary. Many described finding additional resources to support home practice (e.g. apps, books, figurines, music). Four participants (including one who discontinued), expressed a wish for a facilitator-guided CD to help them remember *how* to practise and to make it easier to designate time to it.

Whilst most participants appreciated the non-judgemental stance that facilitators took towards home practice, half felt that facilitators needed to prompt group members more to attempt it.

> "I think it maybe…could've been pushed a little bit more… [for example] "let's see if we can try it once or twice this week… did anyone want to say if they achieved their goals?"" (Marcus).

Group discussion was reported as useful by most participants, but with certain limitations. Half of the participants felt discussions were not always relevant to their learning and limited time for practice, leaving some feeling uncontained and frustrated.

> "I was hoping to do one, focused on pain…and that session was taken up mostly by somebody talking…we didn't get any time for any practice" (Phil).

Overall, reflections were that the group could have benefitted from more structure, to allow greater time for practice so this was better balanced with discussion.

Commitment to practice.

Five participants reported regular home practice during the ML group, and seven participants reported practising at the time of interview. Commitment to practice and effort was regarded as important. Several participants felt this required personal motivation rather than something facilitators could enforce.

> "They'd led the horse to water, so to speak, it's just a case of whether you want to drink or not" (David).

However, levels of commitment varied, with some participants advocating a casual approach and others stronger self-discipline.

> "You don't need to be regimental about doing it" (Mike).

> "I had to kind of force myself" (Emily).

Available free time, mood difficulties and life commitments were common barriers to practice, and six participants reported wanting more discussion around these. Despite barriers, most participants had implemented home practice flexibly to their individual circumstances.

> "I did practise it at home when I had, the inclination" (Terry).

> "Scattered practice throughout the day…only a couple of minutes" (Emily).

> "Forty minutes… on my own… before everyone else gets up" (David).

Regular practice depended on fitting it into one's life, whilst specifics regarding type and duration of practice did not appear to affect perceived benefit or sustainability. Variability in participant approach again demonstrates the flexibility of facilitators to allow individuals to find their own practice methods that work for them.

Making change for the good.

This theme describes the aspects of mindfulness that ML participants saw as crucial to their practice and learning: managing difficulties, connecting and allowing, and compassion. Using attention in a present-focused way had a meaningful impact on mental state and affected participants' relationship to thoughts and other experiences. Connecting and allowing changed as mindfulness practice developed over time, and most participants became more aware of experiences, which in turn appeared to support acceptance of such experiences. For some, this enabled a compassionate way of relating to themselves and others, however for others connection and awareness was overly confronting.

A tool to manage difficulties.

The concept of attentional control emerged throughout interviews and covered a spectrum of experience. Many participants described a *narrowing* focus, suggesting an escape from negative thought cycles and concentration on something tangible (e.g. breath, object).

> "Focusing on a particular point…and blanking everything out" (Mike).

> "In times of real anxiety-filled panic situations I was able to just shut my eyes and concentrate on the breathing" (Marcus).

For five participants the ability to connect to the present and gain distance from distressing thoughts and experiences also allowed for thought diffusion. For a few participants, this was where the positive impact of practice was most evident.

> "Acknowledging the thoughts as just thoughts… gave it a whole new meaning" (Emily).

> "…not living in my thoughts, I'm living at the moment more" (Shirley).

Two participants also referred to diffusion metaphors which they encountered in the group and continued to reflect upon afterwards.

> "Bad experiences…like a train pulling into the station…let it carry on through" (Marcus).

A tool to connect and allow.

Increased awareness was described by five participants, one of whom (Wendy) had dropped out of the group. This related to gaining a different perspective on internal difficulties and allowing themselves to connect with these. Acceptance and non-judgement were often key in supporting this inner connection.

> "I learnt to…. take myself out of the emotional situation and put it…. kind of, at the side, not fight them, just accept them as they are" (Emily).

For a few participants, the concept of living alongside negative experiences felt uncomfortable, with two people finding themselves too "frightened" to connect with confronting internal experiences and leading them to discontinue practice.

> "I don't know what will come out when I open the gates" (Wendy).

Where participants reported an underlying wish for things to be different and discomfort to be 'fixed', there was still acknowledgement that the act of connecting and allowing experiences could be beneficial.

> "I mean, you still want to get rid of those feelings, those memories or thoughts…but until you get rid of them, or until they shrink right back…the mindfulness is the only thing that keeps them under guard" (Terry).

Wendy, despite her fear, reported signing up for another ML course, demonstrating a recognition that self-connection was part of her recovery journey.

> "I think it will be useful just to go over the whole lot again… hopefully get in touch with myself" (Wendy).

Some participants reflected on their experiences of increased connection and present-focus leading to greater opportunity for finding joy and gratitude.

> "All the stresses…just sort of evaporated as I was just looking at the beautiful view" (Mike).

Thus, the ML group helped participants to connect to what was going on within and around them. Since many were experiencing chronic ill health, this often involved meeting difficulty, but there were also opportunities to "lean into" the richer and more joyful experiences in their life.

Compassion.

Half of the participants described an enhanced sense of compassion for self and others following the course and linked this partly to the group environment. Compassion related to better perspective-taking and one participant, a carer, learnt to see what life was like for someone with mental health difficulties, offering him a new way of relating to his wife.

> "I was able to see it from their side as well… it helped me realise…I knew it wasn't my wife's fault" (Mike).

Participants described the impact of increased awareness on relating kindly and honestly to themselves, recognising and accepting their needs.

> "Listen to your heart…you know what feels right" (David).

For one person, this involved recognising the need to step into a calmer place in their mind and gain distance from difficulties. They even developed imaginal coping mechanisms as a new way of engaging in compassionate self-care.

> "I've got this little garden in my head that I can go to. I can lay on the grass and the sunshine is there all the time, not too hot, not too cold. I've got running water in there and I've got birds. I've got *flowers* that are colours you could never imagine" (Terry).

Some participants continued to embed this attitude shift of open awareness and self-compassion into their daily life.

> "Making change for the good, of trying to change a habit, of trying to be kind to myself" (Marcus).

Discussion

This study used a TA approach to explore how participants of different ages and with varied conditions experienced an introductory mindfulness group intervention. Aims were to identify the most and least valued aspects of ML group, assess the balance of practice and discussion, and to make recommendations for improvements. TA identified three themes relating to the experiences of participants in the ML group: being in a group, how mindfulness is taught and learnt and making change for the good. Results indicate that the ML group was valued by participants and involved many aspects that were effective and supportive to them, including group and facilitator supportiveness and the variety of practices. These aspects are captured under "change and valued aspects of the ML group". Many of the participants had also continued to benefit from practice and were using mindfulness in different ways according to their life stage and readiness to connect to their experiences. In terms of least valued aspects, some participants found it difficult connecting to negative experiences, felt uncomfortable with others, or experienced discussions as irrelevant and uncontained. These aspects are described below and informed recommendations.

Change and valued aspects of the ML group

For six out of the eight participants interviewed, the ML group enabled them to learn more helpful ways of relating (to themselves, to others and to their experiences); this in turn fed into effective ways of managing distress. Three elements of the group appeared to facilitate these changes. Firstly, a supportive group atmosphere encouraged sharing and normalising of experiences, intra-group learning, and compassionate thinking. This aligns with research in MBIs which indicates that a "complex interaction" exists between specific factors (mindfulness skills) and non-specific factors (e.g. group processes) making it difficult to ascertain exact change processes (Allen, Bromley, Kuyken, & Sonnenberg, 2009).

Secondly, the variety of mindfulness practices allowed participants to choose which were most appropriate for them. This finding is supported by a recent meta-synthesis which indicated that teaching mindfulness flexibly so it can 'fit to life' can lead to more positive experiences of practice and hence more positive appraisals and engagement (Wyatt, Harper, & Weatherhead, 2014). In the current study, the body scan was reported as most useful, and for three people it allowed a focus on their

relationship with pain. It is therefore advisable that the ML group continues to offer a range of practices, including body-focused practices.

Lastly, facilitators embodied non-judgmental attitudes, clear intentions, kindness, gentleness and flexibility, which had a direct impact on patients' own attitudes to practice and increased the chance of continued engagement. Previous research has supported the idea of facilitator attitude and embodiment as critical in MBIs, helping participants move beyond a conceptual knowledge of mindfulness and towards an experiential one (Crane et al., 2017).

Least valued aspects of the ML group

Several aspects of the group were regarded as less helpful and indicate potential avenues for improvements. Some participants found being in a group uncomfortable and confronting at times, particularly if they felt that too much irrelevant or personal information was shared. Although discussions were seen as beneficial, this was mainly when topics were generally applicable (such as how to manage home practice demands). Facilitators could consider how to better contain and focus discussions, and to ensure there is time for in-session practice and inquiry to promote group-wide learning and motivation.

Some participants reported finding practice aversive, due to feeling uncomfortable when connecting to negative experiences. This led to a degree of avoidance and the use of practice simply to reduce stress. This is a natural human response; to feel aversion towards experiences labelled "unpleasant" (Segal et al., 2002), and may be part of the process of learning mindfulness. To support participants through this, facilitators might consider how to prepare participants for unpleasant experiences, and to explore different ways of using mindfulness, depending on individuals' needs and capacity at each moment.

Continuing benefits after the ML group

All but one of the participants had reportedly continued with meditation practice and the remaining participant had signed up to a second ML course. Reasons for practice varied. Those using it for relaxation or anxiety reduction noted improvements in their response to stressful situations, particularly by using breathing and taking a break from stressors. Participants who had developed their mindfulness skills further continued to benefit from skills in cognitive diffusion and "allowing" uncomfortable

experiences. Being at this stage was associated with having more realistic expectations of mindfulness and a greater degree of readiness to connect to all experiences. This idea is supported by research by Wyatt and colleagues (2014) who found that participant expectations of MBIs influenced the way they engaged in the approach, with open-mindedness (as opposed to expecting a "quick fix") being associated with greater curiosity and non-judgemental attitude.

Improvements and Recommendations.

Regarding improvement elements, one strong theme that emerged was around the amount of in-session practice. Seven participants would have appreciated increased time in sessions for *more* and *longer* practices, balanced by shorter and more relevant discussions. Indeed, compared with manualised MBCT (e.g., Segal et al., 2002) which usually involves a long practice (i.e., 40 minutes) along with several shorter (3-10 minute) practices, the ML group only featured short (5-10 minute) practices. This finding is counter to expectations that an introductory group would prefer shorter practices but it may link to previous points about the way some participants conceptualised and engaged with mindfulness (i.e., in anxiety-management and relaxation terms). It may be that increasing the length of ML group practices allows participants the opportunity to "settle" into their experience and perhaps notice changes within their discomfort when turning towards it.

Further recommendations for improving the ML group are outlined in Table 2.3. These recommendations were shared with facilitators of the ML group and they provided feedback, including ways in which they plan to incorporate recommendations within future groups.

Strengths and Limitations

Results are specific to patients who attended this particular format of a ML group and may not be generalisable to understanding how a heterogenous, mixed-age group receiving MBCT should operate. Since the ML group is also a non-validated version of group MBCT, developed to meet the needs of individuals in an idiosyncratic way, results cannot be generalised to manualised MBIs. Nevertheless, themes that arose may inform other services wanting to run a mixed introduction to mindfulness group across the lifespan.

Efforts were made to recruit past group members regardless of how many sessions they had attended, to avoid potential positive bias. However, those who had attended fewer than half of the sessions (three out of the seventeen people contacted) declined to take part. This meant that all participants interviewed had attended 50% of the course, with most attending all 12 sessions. Results are therefore not generalisable to all patients and may represent only those individuals who felt engaged with the service, wished to offer feedback, and / or who felt able to manage an interview where they reflected upon their experiences. Another potential source of bias could arise from social desirability, with participants reporting more positively on their experiences of the group or service. This was managed by offering telephone interviews and the researcher emphasising her role as separate from the service.

In summary, the ML group was found to be largely acceptable in its current format, with most participants reporting beneficial change due to the group, which has led to long-standing personal mindfulness practice. Recommendations were based mainly around session structure, with the suggestion to allow more time for practice, and to keep discussions time-limited and relevant. These will be used to improve future ML groups, with the hope of engaging more people to take part and continue their practice.

Table 2.3

Recommendations for improving the ML group and service responses/ plans to implement changes

Suggested recommendations	Service response/ plans
Limiting time for discussions with more focus on reflections around practice in session and at home. This would then allow more time for additional and longer practices, potentially having a longer practice at the end of sessions.	Facilitators were aware that practice could sometimes become "squeezed" by long discussions. They plan to lengthen the sessions to 1 1 /2 hours to allow space for additional or longer practices.
Providing CDs with mindfulness practices, if possible led by group facilitators.	Plan to provide CDs of guided-mindfulness practices.
Providing more encouragement and instruction around home practice, emphasising the importance of perseverance, whilst maintaining the non-judgmental attitude that currently exists.	Plans to revise instructions around home practice and the importance of perseverance more frequently.
Depending on resources it may be useful to have ad-hoc telephone "check-ins" between sessions with group participants who appear to be struggling. This could ensure individuals feel comfortable to attend and practice, or if participants would like additional encouragement to practice (this last example could also be via texting).	Facilitators will review whether it is feasible to offer telephone check-ins and if so what form these could take so as not to detract from sharing in group. Facilitators will continue to offer phone or in-person reviews to those who request them and may be more explicit with group members to "ask for help if you're struggling".
Allowing more time to discuss practice barriers, providing and reflecting on ways that group members have introduced/maintained more home practice. If necessary, providing some written tips and ideas for participants to take away (e.g. using stickers, reminders etc.)	Facilitators reflected on the generous time they currently allow for these discussions, and plan to consider whether more information about barriers specifically would be helpful. They have developed a hand-out which includes tips for formal practice and may implement this into future groups.
Providing more encouragement and prompting to use diary sheets, emphasising that these will be kept private and are for the benefit of participants, not for facilitators to check. Seeking feedback on	Facilitators acknowledged the very different needs of group members, and that some may appreciate formal prompting while others may find it pressurising. They will consider further

Suggested recommendations	Service response/ plans
the format/content of diary sheets so these can be enhanced if necessary.	emphasising the usefulness of reflection during and after practice.
Discussion/advice around connecting to negative experiences – normalisation, strategies to manage, and inviting group members to share issues with facilitators privately if needed.	Facilitators will discuss and consider how to introduce and normalise connection with negative experiences, along with strategies to manage and "turn towards" difficult feelings that emerge. They will continue considering participants' fears and hindrances to the group and practice during pre-group assessments but acknowledge that people often aren't able to reflect on these until in the group.
Efforts to create interactions between group members, for example pair or small-group discussions if whole-group interaction is proving difficult for some. This could be helpful at the start to allow participants to become more comfortable with each other.	Facilitators were interested in the idea of small group/paired discussions and thought this could be possible to introduce from week three, once group members feel settled. They acknowledged that some group members may feel more/less comfortable with this.
Giving feedback forms to participants who drop out early to ensure an opportunity to record their experience.	Facilitators will consider giving feedback forms to those who drop out of the group early.
Due to the very differing levels, needs and preferences of those who attend the group, it may be necessary to find out (e.g., during pre-group assessments) what approaches work for individuals and to draw on this when difficulties arise. For example, asking what facilitators might see if they are struggling and what support they would want in sessions; whether people are happy to contribute in a group and if they would appreciate some prompting.	Facilitators reflected on the conversations had with patients in pre-group assessments, which include encouragement around sharing experiences if people feel comfortable to do so. They acknowledged that they currently do not ask about ways in which individuals would like to be prompted and supported during group sessions and will add this question to their ssessment schedule. They will also consider calling individuals when they miss a session to check-in.

References

Allen, M., Bromley, A., Kuyken, W., & Sonnenberg, S. J. (2009). Participants' experiences of mindfulness-based cognitive therapy:"it changed me in just about every way possible". *Behavioural and Cognitive Psychotherapy, 37*(4), 413-430.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology, 3*(2), 77-101.

Crane, R. S., Brewer, J., Feldman, C., Kabat-Zinn, J., Santorelli, S., Williams, J. M. G., & Kuyken, W. (2017). What defines mindfulness-based programs? The warp and the weft. *Psychological medicine, 47*(6), 990-999.

Creswell, J. D., Irwin, M. R., Burklund, L. J., Lieberman, M. D., Arevalo, J. M., Ma, J., . . . Cole, S. W. (2012). Mindfulness-based stress reduction training reduces loneliness and pro-inflammatory gene expression in older adults: a small randomized controlled trial. *Brain, behavior, and immunity, 26*(7), 1095-1101.

Didonna, F. (2009). Mindfulness-based interventions in an inpatient setting. In In F. Didonna (Ed.), C*linical handbook of mindfulness* (pp. 447-462). New York, NY: Springer.

Fledderus, M., Bohlmeijer, E. T., Smit, F., & Westerhof, G. J. (2010). Mental health promotion as a new goal in public mental health care: A randomized controlled trial of an intervention enhancing psychological flexibility. *American journal of public health, 100*(12), 2372-2372.

Gard, T., Hölzel, B. K., & Lazar, S. W. (2014). The potential effects of meditation on age-related cognitive decline: a systematic review. *Annals of the New York Academy of Sciences, 1307*(1), 89-103.

Glaser, B. G., & Strauss, A. L. (1967). The discovery ofgrounded theory: Strategies for qualitative research. Chicago: Aldire.

Gotink, R. A., Chu, P., Busschbach, J. J., Benson, H., Fricchione, G. L., & Hunink, M. M. (2015). Standardised mindfulness-based interventions in healthcare: an overview of systematic reviews and meta-analyses of RCTs. *PloS one, 10*(4), e0124344.

Gu, J., Strauss, C., Bond, R., & Cavanagh, K. (2015). How do mindfulness-based cognitive therapy and mindfulness-based stress reduction improve mental health and wellbeing? A systematic review and meta-analysis of mediation studies. *Clinical psychology review, 37*, 1-12.

Kabat-Zinn, J. (1994). *Wherever you go, there you are: Mindfulness meditation in everyday life.* New York: Hyperion.

Lakhan, S. E., & Schofield, K. L. (2013). Mindfulness-based therapies in the treatment of somatization disorders: a systematic review and meta-analysis. *PloS one, 8*(8), e71834.

Madill, A., Jordan, A., & Shirley, C. (2000). Objectivity and reliability in qualitative analysis: Realist, contextualist and radical constructionist epistemologies. *British journal of psychology, 91*(1), 1-20.

Morone, N. E., Greco, C. M., & Weiner, D. K. (2008). Mindfulness meditation for the treatment of chronic low back pain in older adults: a randomized controlled pilot study. *Pain, 134*(3), 310-319.

Nightingale, D., & Cromby, J. (1999). *Social constructionist psychology: A critical analysis of theory and practice*. UK: McGraw-Hill Education.

Palta, P., Page, G., Piferi, R., Gill, J., Hayat, M., Connolly, A., & Szanton, S. (2012). Evaluation of a mindfulness-based intervention program to decrease blood pressure in low-income African-American older adults. *Journal of Urban Health, 89*(2), 308-316.

Philippot, P., Nef, F., Clauw, L., de Romrée, M., & Segal, Z. (2012). A randomized controlled trial of mindfulness-based cognitive therapy for treating tinnitus. *Clinical psychology & psychotherapy, 19*(5), 411-419.

Segal, Z. V., Williams, J. M. G., & Teasdale, J. D. (2002). *Mindfulness-based cognitive therapy for depression: A new approach to relapse prevention*. New York: Guilford.

Strauss, C., Cavanagh, K., Oliver, A., & Pettman, D. (2014). Mindfulness-based interventions for people diagnosed with a current episode of an anxiety or depressive disorder: a meta-analysis of randomised controlled trials. *PLOS one*, *9*(4), e96110.

Ulrichsen, K. M., Kaufmann, T., Dørum, E. S., Kolskår, K. K., Richard, G., Alnæs, D., . . . Nordvik, J. E. (2016). Clinical Utility of Mindfulness Training in the Treatment of Fatigue After Stroke, Traumatic Brain Injury and Multiple Sclerosis: A Systematic Literature Review and Meta-analysis. *Frontiers in Psychology, 7*(912). doi:10.3389/fpsyg.2016.00912.

Wyatt, C., Harper, B., & Weatherhead, S. (2014). The experience of group mindfulness-based interventions for individuals with mental health difficulties: A meta-synthesis. *Psychotherapy Research, 24*(2), 214-228.

Zeidan, F., Martucci, K. T., Kraft, R. A., Gordon, N. S., McHaffie, J. G., & Coghill, R. C. (2011). Brain mechanisms supporting the modulation of pain by mindfulness meditation. *Journal of Neuroscience, 31*(14), 5540-5548.

Blank page

Main Research Project

Exploring factors that influence foster carer responsiveness to children: carer emotional distress, emotion regulation and placement arrangements

Lucy V. Armstrong

Department of Psychology, University of Bath

Academic supervisors: Dr Catherine Hamilton-Giachritsis & Dr Rachel Hiller

Regional supervisor: Dr Sasha Walters

Word count: 5500

Target journal: Child Abuse and Neglect

Blank page

Introduction

There are approximately 90,000 young people in care in the UK, the majority of whom (>60%) are in foster care placements (Department for Education, 2017). Children have often experienced negative and unpredictable emotional climates prior to being fostered, with the most common reason for entering care being exposure to significant abuse and/or neglect. Such early experiences can have a substantial impact on a young person's well-being, leading to increased vulnerability to developing behavioural, social and psychological difficulties (Brown & Ward, 2013; Ford, Vostanis, Meltzer, & Goodman, 2007). In attachment terms, fostered children have often lacked the adequate care and safe environments to develop secure bonds with initial caregivers (Crittenden, 1983), leading them to internalise unhealthy working models of their relationships with adults. These insecure early attachment styles can have a significant impact, negatively influencing children's interactional patterns with others in later relationships (Bowlby, 1988). Fortunately, research has found that attachment styles are dynamic and can change depending on whether there are opportunities for learning more positive ways of interacting, for example in a foster care setting (Lamb, Gaensbauer, Malkin, & Schultz, 1985). When a foster placement cultivates secure attachment bonds between carer and child, this can additionally aid recovery from early developmental and emotional harm (Golding, 2003). However placement breakdowns can also be common, especially for children who are struggling with emotional and/or behavioural difficulties (Hiller & St. Clair, 2018). Understanding the various elements that influence successful attachments and placements in foster care are needed. This paper explored factors associated with the carer-child relationship, including carer responsiveness to child distress, and the ways in which caregiver emotional distress and emotion regulation (ER) influence this.

Caregiver responsiveness

Research with biological families suggests that caregiver responsiveness to child emotional expression is a key part of their role in aiding emotional and social development. Adaptive responses, such as showing acceptance, support and comfort in response to child distress, have been associated with children's own pragmatic coping skills and reduced reactivity (Denham, Bassett, & Wyatt, 2007). Conversely, children of

parents who respond in maladaptive (i.e., punitive, minimising and invalidating) ways to their distress have poorer ER and coping skills, which in turn has been associated with poorer social competence (Denham et al., 2007; Topham et al., 2011).

Within foster families, children have already experienced maladaptive treatment from early caregivers, informing their socioemotional development and leading them to expect particular responses from adults (Hughes & Golding, 2012). Thus, the way in which foster carers respond to children's distress is crucial and may mitigate the harmful effects of these earlier experiences. For example, in responding calmly, openly and sensitively carers communicate to children how to manage their own difficult feelings and show acceptance of them.

Indeed, foster family research has found that lower levels of harsh discipline and carer annoyance, and higher levels of carer acceptance are associated with positive child adjustment and fewer internalising behaviours (see Orme & Buehler, 2001 for a review). In addition, (Schofield & Beek, 2005) investigated resilience and protective factors for fostered children. This included a focus on carer sensitivity (i.e., the ability to empathise with and reflect on the child's position, thoughts and feelings, and their own inner experiences and parenting styles). Results found that children of sensitive foster carers were more likely to make good progress during placements (83% of foster children in their care) compared with children of less sensitive carers.

Caregiver emotional distress

A caregiver's capacity for positive parenting and responsiveness is contingent on several factors including their own levels of well-being and resilience (Belsky, 1984). Foster carers can face a range of challenges in their role which significantly impact their well-being and cause emotional distress. For example, children who have experienced abuse and/or disrupted attachment may have developed behavioural strategies that are adaptive under threat (e.g., being withdrawn or aggressive). However, once in a secure placement, these behaviours become maladaptive, difficult to manage, and can often inhibit forming secure and trusting interpersonal relationships.

Despite carers' initial motivations and best efforts to create safe opportunities for children, it can be extremely difficult for carers to bond with children (Whenan, Oxlad, &

Lushington, 2009). Over time, carers can feel distressed, helpless and unwilling to provide further care and, in some cases, this can lead to placement breakdown (Howe & Fearnley, 2003). For children, subsequent exposure to multiple placements and carers with varying skills can further compound difficulties and reduce psychosocial development and resilience (Harden, 2004). Previous studies have also found that foster carer stress and placement difficulties can also lead to carers leaving the profession (Farmer, Lipscombe, & Moyers, 2005; Selwyn, Wijedasa, & Meakings, 2014). Hence, for the benefit of both child and carer, and for placement success, it is important to work with foster families around ways to improve carer well-being.

It is well understood that foster carers generally find it difficult to balance their needs with the needs of individuals in their care, most often prioritising the child's well-being over their own, even when under considerable strain (Pickin, Brunsden, & Hill, 2011). However, higher levels of stress can also make it harder to implement adaptive parenting strategies. Research in biological families has found that parental stress related to child behavioural problems can inadvertently disrupt positive parenting practices (Webster-Stratton & Reid, 2010). As caregivers become more punitive in their responses, a negative cycle between child behavior and carer response is maintained.

Foster research has also linked high levels of carer distress and interpersonal problems, and higher potential for being abusive (Timmer, Sedlar, & Urquiza, 2004). In this study, carers who fit a profile of being highly distressed with higher abuse potential were also more likely to terminate parenting interventions early, suggesting that they may find it harder to receive help (Timmer et al., 2004). This study aside, there is limited understanding in the field around of the link between foster carer emotional distress and specific responses to children in care. In addition, there is limited knowledge about the impact of fostering multiple children, which UK figures show is gradually increasing (Ofsted, 2018). One study found a trend between higher numbers of children in a placement and increasing problem behaviours for each child (Moore, Osgood, Larzelere, & Chamberlain, 1994). It is likely that carer responsiveness to child distress is influenced by the total number of children under their care; these are associations that this study will investigate.

Emotional regulation

One core cognitive process that has been linked both to emotional well-being and the ability to manage potentially stressful situations, is emotion regulation (ER). Gross and John (2003) operationalised two specific forms of ER, which have received significant research attention: cognitive reappraisal and expressive suppression. Cognitive reappraisal refers to the *adaptive* ability to change our interpretations of potentially distressing situations and in doing so adapt our emotional response (Gross, 2002). For example, getting lost on the way to a social event, one could become stressed and/or self-critical, however a reappraisal such as "I'm sure people won't mind that I'm late" or "never mind, life happens" may reduce these feelings, resulting in a more balanced state of mind. Conversely expressive suppression is generally considered a *maladaptive* form of response modulation, which attempts to inhibit the behavioural expression of emotions whilst we are aroused (Gross & Levenson, 1993). For example, trying to prevent oneself from crying when upset by keeping busy and using distractions, or using minimising statements such as "I should be grateful, at least I have a job/my health/friends".

Research has demonstrated links between ER strategies and aspects of well-being. For example, Gross and John (2003) found that cognitive reappraisal was linked to higher positive emotional expression and self-esteem, while expressive suppression was associated with lower life satisfaction and mental health symptoms. ER has also been associated with help-seeking behavior, with suppressors tending to have lower levels of social support and closeness to other (Srivastava, Tamir, McGonigal, John, & Gross, 2009). Research in biological families has demonstrated that parent ER influences interactions and responses to children (Bariola, Hughes, & Gullone, 2012; Morris, Silk, Steinberg, Myers, & Robinson, 2007).

Taken together, these research findings imply that it may be useful to explore the ways that foster carers regulate their emotions, and the impact this has on their distress levels and responsiveness to children. This knowledge could help explain why some carers are able to adapt to challenging situations more easily than others and could provide insight into placement breakdown and longevity in the profession. Moreover, if found to be a significant factor, ER could be targeted by carer training programs that aim to

improve the carer-child relationship, thus bridging a significant gap in current knowledge and evidence-based practice.

Aims

The current study aimed to explore the links between carer responsiveness to child distress, carer emotional distress and ER, and characteristics associated with care (e.g., the number of child dependents). Hypotheses were as follows:

1) Foster carer emotional distress would be associated with how they endorse responding to their child in distress. That is, higher self-reported depression, anxiety and stress would be associated with more negative (unsupportive, distress) responses, and fewer positive (supportive, expressive encouragement) responses.
2) Foster carer ER strategies (i.e. cognitive reappraisal) and expressive suppression) would mediate the relationship between carer distress and responsiveness to children (positive and negative).
3) Current number of child dependents would predict carer responses to children in distress. That is, caring for a higher number of children would be associated with the carer endorsing more negative (unsupportive, distress) responses, and fewer positive (supportive, expressive encouragement) responses.

Demographic factors relating to the foster carer will also be explored as potential covariates including:

- Foster carer age and number of years in the caring profession, as research suggests older carers bring a wealth of experience and expertise and thus may be better adept at responding effectively and sensitively to challenges (Clarke, 2009). In addition, more experienced carers are likely to have established networks of social and professional support, moderating their stress levels (Farmer et al., 2005).
- Duration of the child's placement. Research suggests that over long-term placements carers have an extended opportunity to understand and respond to children's needs, and children can learn to experience them as a secure base

(Schofield and Beek, 2005). In addition, a study by Horwitz, Balestracci and Simms (2001) found that children's adaptive behaviours improved over the course of their foster placement, reducing carer burden.

- Age of child, as research has shown older children have higher rates of psychiatric disorders (McMillen et al., 2005) and are more likely to have placement disruptions than younger children (Smith, Stormshak, Chamberlain, & Bridges Whaley, 2001). Both of these factors suggest higher levels of difficulty and burden on carers.
- Number of stressful life events. Previous research has found that higher levels of carer strain related to previous placements and other stressful and impactful life events was associated with poorer parenting practices and less commitment to the child (Farmer et al., 2005).

Method

Participants

Foster carers were eligible to participate if they had been working in the profession for at least one year and if they currently had a foster child aged 4-12 years in their care. This age range was chosen to fit with some of the item descriptions on one of our measures (Coping with Children's Negative Emotions Scale; Fabes, Eisenberg, & Bernzweig, 1990) such as "If my child falls off his/her bike and breaks it, and then gets upset and cries, I would…". Carers with more than one foster child in their care were asked to focus on just one child with whom they have the most difficult relationship when answering scenario-based questions. Carers registered with both fostering services and private agencies were included and could take part irrespective of the type of care they provided (long term, short term, emergency, respite etc.).

A total of 121 foster carers consented to participate in the study, of which 86 were included in the final analyses (see Appendix 3a for full flow-chart). The key reasons a foster carer was excluded from final analyses were:

1) reporting on a child who fell outside the age range
2) incompletion of more than 50% of items

Procedure

The study protocol was approved by the University of Bath Research Ethics Committee (Ref: 18-122). Participants were recruited via posters, local newspapers and forums, and online advertising (purposive sampling). Generic platforms such as Facebook, Twitter and Gumtree were used alongside university advertising channels and foster services/agencies' webpages and social media. The highest number of participants appeared to have been recruited via paid Facebook advertising, based on the timings of completed surveys. This approach utilised targeted advertising for those "aged 18-65+", with "interests/job title: foster care" and "living in the UK". Participants were directed to an anonymous online survey (Qualtrics) where they completed all questionnaires. Participants were provided with information about the study and required to complete informed consent before completing survey questions. Questionnaires took approximately 10-15 minutes to complete, and participants were given debrief information at the end of the survey. Participants were asked to choose a charity to select, and informed that a donation would be made on their behalf to thank them for their participation.

Measures

Demographics.

A brief demographic questionnaire collected details on carer age, gender, length of time in profession (in months), type of service associated with (foster service or private agency), type of placements offered (short-term, long-term, or "multiple" types of placement including long, short, respite, emergency etc.), total number of child dependents (fostered and non-fostered), and age of focal child for completing the questionnaires.

Emotion regulation.

The *Emotion Regulation Questionnaire* (ERQ; Gross & John, 2003) captured the degree to which carers endorse various ER strategies across 10-items. Each strategy is rated on a scale of one (strongly disagree) to seven (strongly agree). The ERQ is a 10-item questionnaire with two subscales representing two independent types of regulation strategy: Cognitive Reappraisal (six items; score range of 6-42; e.g., "When I'm faced

with a stressful situation, I make myself think about it in a way that helps me stay calm"), considered to be an adaptive strategy, and Expressive Suppression (four items; score range of 4-28; e.g., "I keep my emotions to myself"), considered to be maladaptive. There are no clinical cut-offs for the measure, however authors provided the following average scores for males and female undergraduates (respectfully): Expressive Suppression = 3.64; 3.14, and Cognitive Reappraisal = 4.6; 4.61. The measure has been found to have good internal consistency and test-retest reliability of .7 (Gross & John, 2003). Adequate internal consistency was replicated in the current study (Cognitive Reappraisal: α = .90; Expressive Suppression: α = .73).

Responsiveness to child distress.

The *Coping with Children's Negative Emotions Scale* (CCNES*;* Fabes et al., 1990) provides 12 hypothetical situations in which children have shown distress (e.g., "my child becomes angry because he/she is sick or hurt and can't go to his/her friend's birthday party"). Carers were asked to indicate how likely they would be to respond in six possible ways to these situations on a Likert scale ranging from one (very unlikely) to seven (very likely). Three subscales measure recognised maladaptive or negative support styles: Distress Reactions (e.g., "get angry at my child"), Minimising Reactions (e.g., "tell my child not to make a big deal out of missing the party"), Punitive Reactions (e.g., "send my child to his/her room to cool off"). On each sub-scale, a high score represents a high use of a maladaptive support style (score range = 7-84). Three subscales measure adaptive support styles: Expressive Encouragement (e.g., "encourage my child to express his/her feelings of anger and frustration"), and Emotion-Focused Reactions (e.g., "soothe my child and do something fun with him/her to make him/her feel better about missing the party"), Problem-Focused Reactions (e.g., "help my child think about ways that he/she can still be with friends (e.g., invite some friends over after the party)"). On each sub-scale, a high score represents a high use of an adaptive support style (score range = 7-84). (Fabes, Poulin, Eisenberg, & Madden-Derdich, 2002) found the measure to have good construct validity and reliability (Cronbach alpha ranging from .69 to .87 for the various subscales, across two studies).

There are no clinical cut-offs for this measure, however in the above studies by Fabes et al. (2002) average scores across non-clinical parent samples were as follows: Punitive Reactions = 1.95; Minimising Reactions = 2.21; Expressive Encouragement = 5.38; Emotion-Focused Reactions = 5.45; and Problem-Focused Reactions = 5.88.

Authors of the CCNES measure conducted a principle components factor analysis, finding that only four of the six subscales had Eigenvalues of >.5 (Fabes et al., 2002). This led to collapsing of Minimising and Punitive Reactions subscales into a single dimension of "non-supportive response", and Emotion and Problem-focused Reactions into a single "supportive response". Authors concluded that caregivers may find it difficult to differentiate between these responses, potentially because they may co-occur in the same moment. Based on this evidence and reasoning, the current study followed this same approach, investigating four rather than six subscales. Adequate internal consistency was replicated ("Supportive responses": $\alpha = .83$; "Non-supportive responses": $\alpha = .83$; Expressive Encouragement: $\alpha = .79$). Due to its low reliability (.57), the Distress Reactions subscale was dropped from further analyses.

Emotional distress.

To measure distress, carers completed the short-form *Depression Anxiety and Stress* questionnaire (*DASS*-21; Henry & Crawford, 2005), which consists of 21 items with a range of four responses, indicating the frequency of symptoms observed in the past week, from zero (did not apply to me at all) to three (applied to me very much or most of the time). Three subscales represent different negative emotions: Depression (seven items; e.g., "I felt that life was meaningless"), Anxiety (seven items; e.g., "I felt scared without any good reason"), and Stress (seven items; e.g., I found it hard to 'wind down'"). Results are doubled to give the long-form scores, which can range from 0 to 42 for each subscale, with higher scores representing higher emotional distress. Clinical cut-off scores for depression, anxiety and stress subscales (respectively) are as follows: "normal" = 0-9, 0-7, 0-14; "mild" = 10-13, 8-9, 15-18; "moderate" = 14-20, 10-14, 19-25; "severe" = 21-27, 15-19, 26-33; "extremely severe" = 28+, 20+, 34+. The DASS-21 is a well-established measure with high validity and internal consistency (Henry &

Crawford, 2005). Adequate internal consistency was replicated in the current study (Depression: α =.86; Anxiety: α =.86; Stress: α =.89)

Life Events.

The *Life Events Checklist (LEC*; Blake et al., 1995) is a 17-item measure of different types of exposure to potentially traumatic events (e.g., "fire or explosion", "life threatening injury or illness"). The LEC is amongst the most widely used tests to assess trauma exposure and post-traumatic events and is routinely administered before the use of a "Gold Standard" CAPS (Clinically-administered PTSD Scale) interview. As a screening measure it is not intended to provide clinical cut-offs for diagnostic purposes, and descriptive data from original authors is not accessible. However, a more recent study of college students (Gibson et al., 2014) found that individuals endorsed an average of 2.05 traumas (range 0-11) using the measure. The LEC has shown adequate temporal stability and good convergence with other measures of trauma experience, both in clinical and non-clinical populations (Gray, Litz, Hsu, & Lombardo, 2004). Exposure to traumatic events can be indicated on a categorical scale (a =*happened to me*, b= *witnessed it*, c= *learnt about it*, d= *not sure*, e= *does not apply*). In the paper by Gray and colleagues (2004) both full-scale responses and "direct trauma exposure" were considered. For the latter, a score of one was assigned only to direct experiences of events, and a zero for all other responses (score range from 0 to 14; three items reference others). For the present study, researchers aimed to explore life events as a covariate within the regression models. This was to include both direct experiences and a combined score of direct and witnessed events (potential score range of 0-31). However, direct experiences were not significantly correlated with other variables and the combined score had low reliability (.58), therefore this variable was dropped from further analyses.

Data Analytic Strategy

Power calculations (G*Power 3.1) estimated that 77 participants would be necessary to detect a medium effect size using Linear Multiple Regressions, with a power of .80 and probability error of 0.05. Final participant numbers were 86 overall (75 were included in the most complex regression), and post-hoc analyses showed that power = .79.

First, a bivariate correlation matrix was run to explore associations between the variables (see Appendix 3c). Variables were only included in the subsequent analyses if there were significantly correlated ($p < .05$). Since ER was not significantly correlated with carer emotional distress nor carer responsiveness it was dropped from further analyses. Linear regressions were conducted to investigate (1) the relationship between foster carer emotional distress and carer responsiveness; (2) the relationship between the number of child dependents and carer responsiveness. Subsequently, a hierarchical linear regression was run to control for carer and child age within these associations.

Where participants had >50% data missing overall, they were fully excluded from analyses. Where there was <10% missing data for specific subscales, the mean score for that subscale was substituted. In the case of 10-50% missing data, specific subscales were excluded from analyses. Upon exploring the data for assumptions of normality, it was apparent that many of the subscale scores were significantly skewed and this was confirmed by Kolmogorov–Smirnov tests ($p<0.05$). Square root and Logarithm10 transformations were unsuccessful, therefore median values are reported in Table 3.2 in addition to the interquartile ranges (IQR). To allow for non-normally distributed data and the existence of outliers, non-parametric correlations (Spearman's Rho) were used and bootstrapping was applied for regressions. A Bonferroni correction was not used, due to the conservatism of this approach and the fact that bootstrapping had already been applied, accounting for the dependence across tests (Gelman, Hill, & Yajima, 2012). DASS subscales were significantly correlated (above .70), however collinearity statistics (VIF and Tolerance) were within acceptable limits (Menard, 1995; Myers, 1990).

Results

Descriptive statistics

The sample included 86 foster carers, aged between 25 and 70 years, and with a range of one to five children total in their care (fostered and non-fostered). Demographics details are provided in Table 3.1.

Table 3.1

Foster carer demographic information

Sample characteristics	
Carer characteristics	
Age in years (M [SD])	50.33 (8.6)
Proportion – n (%) Female	76 (88.4%)
Ethnicity – n (%) White British	81 (94.1%)
Employed by foster service – n (%)	43 (50%)
Employed by private agency – n (%)	43 (50%)
Time in profession in years (M [SD])	7.51 (6.4)
Type of care offered: short term – n (%)	19 (22.1%)
Type of care offered: long term – n (%)	45 (53.2%)
Type of care offered: multiple (long, short, respite, emergency etc.) – n (%)	11 (12.8%)
Total number of child dependents (M [SD])	2.43 (1.2)
Child characteristics	
Child age (M [SD])	8.68 (2.6)
Time on placement in months (M [SD])	22.6 (19.9)

Descriptive characteristics were compared between those who were included in the study and 24 carers who were either excluded or who consented but did not complete any further questionnaire items. There were no significant differences in terms of average age, ethnicity, gender, type of service or placement type, however included participants had spent significantly fewer years in the profession (mean=7.51 years; p=.048) compared with those who were excluded/did not complete (mean=10.58 years).

In terms of main variables, foster carers reported higher use of Cognitive Reappraisal (i.e., adaptive) strategies than Expressive Suppression (maladaptive) strategies, and scores for depression, anxiety and stress were within the "normal" range, based on the DASS-21 cut-offs. Eighty carers reported a high use of adaptive responses and low use of maladaptive responses (see Appendix 1b). The remaining four carers reported low maladaptive responses but also low adaptive responses particularly with regards to expressive encouragement. Table 3.2 gives the median and interquartile ranges (IQR) for all raw variable data.

Table 3.2

Foster Carer Variable Descriptives

Measure	N	Range (Median)	IQR
Parental Response			
Expressive Encouragement	83	1.55-7 (5.92)	1.25
Supportive responses	84	4.5-7 (6.06)	.83
Non-supportive responses	80	1.04-3.54 (1.65)	.63
Emotion Regulation			
Expressive Suppression	85	1-7 (3.25)	1.75
Cognitive Reappraisal	84	1-7 (5.50)	1.71
Emotional Distress			
Depression	85	0-19 (4.00)	5.00
Anxiety	85	0-16 (2.00)	2.00
Stress	83	0-18 (10.00)	6.00

Note. Distress Reactions and Number of stressful life events have been omitted due to low reliability. IQR= Interquartile Range; Information on the possible range of scores for each scale is presented in the Methods. Measures/subscales: Parental response=Coping with Children's Negative Emotions Scale. Supportive responses combines Emotion-Focused Reactions and Problem-Focused Reactions subscales. Non-supportive responses combines Minimising Reactions and Punitive Reactions subscales. Emotion Regulation=Emotion Regulation Questionnaire. Emotional distress=Depression, Anxiety Stress Scales. Number of stressful life events=Life Events Checklist.

Associations between carer emotional distress (DASS), ER strategies, carer responsiveness, and number of child dependents

Spearman's Rho correlations (see Appendix 3c) found that lower levels of depression, anxiety and stress were each associated with more supportive responses to child distress ($r = -.29$ to $-.39$, $p < 0.05$). Additionally, the lower the number of child dependents (both fostered children and total dependents), the more likely carers were to use expressive encouragement in response to child distress ($r = -.42$, $p < .01$), and the more likely they were to rely on cognitive reappraisal to manage their own emotions ($r = -.27$, $p < .05$). ER was not significantly associated with DASS subscales nor carer responsiveness to child distress, therefore there were no grounds to conduct a mediation analysis (i.e., "the effect of X on M which, in turn, affects Y" could not be demonstrated; (Hayes, 2017). The only

demographic information associated with DASS subscales or carer responsiveness was carer and child age.

Carer emotional distress and responsiveness to child

Carer emotional distress was found to separately predict their use of supportive (i.e., emotional and problem-focused) responses, with lower depression scores being associated with more supportive responses (R^2=.079, F (1, 81) = 6.93, p= .01). Lower carer anxiety also predicted more use of supportive responses (R^2 =063, F (1, 81) = 5.47, p= .03). Lastly, lower carer stress predicted more use of supportive responses (R^2=.014, F (1, 79) = 13.21, p= .00).

DASS subscales were entered into a hierarchical regression model to explore their unique contribution to the variance of supportive parental response (see Table 3.3). Carer and child age were controlled for in step one of the regression, explaining a non-significant 3.9% of the variance of supportive responses (p=.239). After entering DASS subscales (depression, anxiety and stress) at step two, the total variance explained by the whole model was 20.4%, F (5, 69) = 3.53, p=.007. The three variables accounted for an additional 16.5% of the variance of supportive responses, after controlling for age of carer and child (R^2 change =.165, F change (3, 69) = 4.75, p=.005). Bootstrapped coefficients in the final model showed that depression and stress equally contributed the most to the model. However, as would be expected with such overlapping constructs, neither contribution was significant.

Table 3.3

Hierarchical regression model of Supportive Responses to child distress, controlling for child and carer age

						BCa CI (95%)	
	R	R^2	R^2 change	B	SE	Lower	Upper
Step 1	.197	.039					
Child age				.000	.027	-.050	.049
Carer age				.014	.008	-.002	.030
Step 2	.451	.204*	.165*				
Child age				.002	.022	-.038	.037
Carer age				.014	.007	-.001	.028
Depression				-.029	.040	-.105	.072
Anxiety				-.002	.043	-.095	.082
Stress				-.029	.021	-.069	.005

Note. Results are bootstrapped (1000 samples). BCa CI= Bias Correction accelerated Confidence Intervals. *p=.005

Number of child dependents

Results found that the lower the number of children (fostered and non-fostered) being looked after by carers, the more likely carers were to use expressive encouragement in response to child distress (see Table 3.4). When a hierarchical multiple regression was run, controlling for child and carer age, total number of child dependents explained an additional 6.2% of the variance in carer Expressive Encouragement (Bootstrapped results: R^2 change=.062, *F* change (1, 74) = 5.10, p=.027). Cognitive Reappraisal was controlled for in a separate regression (as it significantly correlated with total number of children), however this did not appear to make a significant difference when predicting Expressive Encouragement from number of child dependents. The same analysis was run with just numbers of fostered children, but there was no significant result.

Table 3.4

Hierarchical regression model of Expressive Encouragement responses to child distress, controlling for child and carer age

	R	R^2	R^2 change	B	SE	BCa CI (95%) Lower	Upper
Step 1	.207	.043					
Child age				.077	.013	-.019	.183
Carer age				-.008	.056	-.037	.022
Step 2	.323	.104*	.062*				
Child age				.054	.061	-.052	.168
Carer age				-.009	.013	-.039	.020
Total number of child dependents				-.195*	.080	-.356	-.044

Results are bootstrapped (1000 samples). BCa CI= Bias Correction accelerated Confidence Intervals. *p<.05

Discussion

This study investigated the relationships between foster carer emotional distress, ER strategies, responsiveness to child distress, and number of children in the home. Results indicated that carer distress and the number of children in the home significantly related to carers' responsiveness to child distress, even when child and carer age was controlled for. Specifically, carers who reported lower levels of depression, anxiety and stress were more likely to give supportive (i.e. emotion and problem-focused) responses, and those with a lower number of child dependents were more likely to encourage a distressed child to express themselves. Carers' ER strategies were not significantly associated with their distress levels, nor their responsiveness to child distress. It must be highlighted that this particular foster carer sample reported low levels of distress and generally responded positively and supportively to child distress; the implications of this will be discussed.

The link found between carer emotional distress and responsiveness to child distress supported our first hypothesis and is in line with previous, albeit limited, research. Foster family research has found that carers under considerable stress before and during placements used poorer parenting strategies, were less likely to respond

sensitively to children, and some showed increased levels of aggression towards children (Lipscombe, Moyers, & Farmer, 2004). In addition, researchers (Morgan & Baron, 2011) found a negative relationship between levels of depression, anxiety and stress in foster carers and caregiver self-efficacy (which authors link to higher parenting competence and sensitivity). In the present study, combined DASS subscales accounted for 16.5% of the variance of carer responses, and when investigated individually, depression, anxiety and stress (due to high correlations) did not uniquely contribute to the prediction.

Fewer child dependents were significantly associated with higher levels of reported expressive encouragement from carers, partially supporting our third hypothesis. This represented a novel finding, particularly as this related to the *total* number of children in the household, not just fostered children. This finding could suggest that the action of encouraging child emotion expression takes time, patience and cognitive resource, all of which may be more abundant when foster carers have fewer children to look after.

Though there is limited research on the link between number of children in care and carer responsiveness, some studies have captured the impact of multiple foster children on carers and others. Research by Moore and colleagues (1994) found positive associations between the number of foster children in a household and problem behaviours for each child, resulting in higher burnout for carers and fewer opportunities for positive interactions. Where carers also have their own children family dynamics can become negatively impacted as the needs of fostered children can seemingly outweigh the needs of biological children; this can lead to relationship difficulties between carers and fostered children (Twigg & Swan, 2007). The mean number of child dependents in the current study was 2.43 and the majority of carers reported a reasonably high use of expressive encouragement (median score = 5.92, out of a maximum score of 7). This could suggest that caring for 2-3 children was practical for these carers to manage, allowing them time for sensitive and encouraging conversations with children. As recent reports show 33% of foster carers are approved to care for three or more children (Ofsted, 2018), it may be useful to look specifically at this group and the impact of higher numbers of children.

Regarding ER, results contradicted our final hypothesis and suggest that the ways in which carers modulate and express emotions does not impact their distress levels (and vice versa), nor how they respond to children in their care. This was surprising considering previous research which has found positive associations between expressive suppression and negative emotional experience, and negative associations between cognitive reappraisal and negative emotional experience (Bariola, Gullone, & Hughes, 2011; Gross & John, 2003). As far as we are aware, this was the first study to investigate links between ER and caregiver response style, and results suggest that ER may not play a significant part in carer responsiveness. Such findings may be contextualized in a number of ways; firstly, the modulation and expression of emotions is often a subconscious process, one in which individuals may struggle to report accurately. It is likely that carers (and people more generally) are biased in their perceptions of how emotionally aware and open they are, leading them to underestimate how often they suppress their feelings, or overestimate how they use reappraisal strategies. Secondly, researchers who have critiqued the construct of ER suggest that we may only understand and measure it in relation to its context (Cole, Martin, & Dennis, 2004). Since the present study utilised the ERQ (a measure of general, rather than contextual ER strategies), this may not have permitted context-specifc responses related directly to carer-child responsiveness in challenging situations. A more specific measure of ER relating to caregiver stress or scenarios may be more relevant and useful for future research.

It is important to consider the present findings in the context of this specific foster carer sample and remain tentative about how results are generalised. Descriptive results suggest that these carers were a non-distressed group, their DASS scores being within "normal" range and in line with those of a representative UK non-clinical population (Henry & Crawford, 2005). Regarding ER, carers in the present study reported using significantly higher cognitive reappraisal than expressive suppression strategies. Scores for Expressive Suppression were in line with those reported by undergraduate students in the original ERQ study (Gross & John, 2003) and carers' Cognitive Reappraisal scores were higher, suggesting that compared with other non-clinical samples these foster carers used more adaptive ways of regulating their emotions. Overall scores on the CCNES measure suggested that foster carers did not have problematic reactions to children in

distress, endorsing more supportive than unsupportive responses. Most carers also tended to endorse encouraging (rather than discouraging) child emotional expression.

These results could suggest a couple of possibilities: Firstly, that the carers in this study represented a particularly robust group and were perhaps more drawn to research participation than those struggling, suggesting a degree of self-selection bias. Secondly, that there may be a degree of social desirability associated with adaptive responses (this is discussed more in the limitations section). Other foster carer research has similarly found low reports of carer distress (Whenan et al., 2009) and low reports of negative parenting responses (Healy & Fisher, 2011), which authors attributed to a potential reluctance to diverge such information. This highlights the importance of considering recruitment strategies and foster carer samples in research if we want to understand a range of parenting responses or explore more distressed experiences of caring.

Strengths and limitations

Findings added to the literature around important aspects of foster care including the emotional experiences of carers, caring for multiple children, and the impact these can have on carer responsiveness to child distress. These are important areas to investigate within this population as children often present with emotional and behavioural difficulties and are highly attuned to the responses of caring adults, whilst carers can become overwhelmed by their responsibilities. Our modest sample size meant our study was slightly underpowered, however it was reasonably large for a foster carer study (a recent review of foster carer research included 18 studies, of which 15 used smaller samples than this study; (Blythe, Wilkes, & Halcomb, 2014). Finally, the recruitment methods used in this current study, particularly the use of social media advertising, was advantageous in that it allowed for a broad range of individuals to take part and complete anonymity was offered.

There are several limitations to the current study and ways in which improvements could be made. As previously mentioned, this study relied on the self-report of foster carers which may have led to social desirability (SD) bias and the reporting of particularly low (maladaptive) scores. Additional steps could have reduced potential bias such as utilising a questionnaire for measuring SD as Fabes and colleagues

(2002) did in their study of carer responsiveness. Single-informant bias may have also been reduced by using an observation approach to assess carers' responsiveness to children. Fabes suggests "an important step in determining the validity of the CCNES is to relate parents' responses to observed parenting behaviors" (2002, p. 306). Though beyond the scope of this project, future research investigating caregiver responses could ascertain whether third person observations align with carers' self-perceived actions.

Another potential limitation is the use of measures (i.e., CCNES, ERQ) which lack clinical cut-off information; this makes it difficult to interpret when strategies and responses become adaptive or maladaptive. This presents a larger question about the context of caregiving behaviours and emotional responses in general and how well we can really understand the helpfulness of these through self-report questionnaires, which may be completed away from relevant environments. Again, a combination of self-report and situation-specific observations may be useful for future studies. Where this is lacking for the current study, findings about quality of care provision must be interpreted with some caution.

Clinical implications and future directions

Limitations notwithstanding, this study does have some important implications for foster care services and agencies, including the need to maintain and enhance carer well-being and to begin to consider the impact of multiple children in their care (see Table 3.5).

Table 3.5

Clinical implications and future directions for foster services

Implications/ Future research
Findings support the continued need to offer adequate foster carer training as a top priority within services, to benefit both children and carers alike. Research has highlighted the impact of foster carer training on well-being and carers' ability to manage the emotional and behavioural difficulties of fostered children (Linares, Montalto, Li, & Oza, 2006; Macdonald & Turner, 2005; Whenan et al., 2009).
Findings support the implementation of parenting programmes designed with foster carers in mind such as NPP (Neuro-Physiological Psychotherapy; (McCullough, Gordon-Jones, Last, Vaughan, & Burnell, 2016), which include specific focus on carers' own emotional well-being and coping strategies. However more research is

Implications/ Future research
needed before these "wrap-around" interventions are rolled out more widely in services. Though fostering services struggle with carer shortages (Ofsted, 2018), they must ensure that carers receive adequate training before vulnerable children are placed with them. Without appropriate training preparation, this could have detrimental effects on both carers and children in the short-term, and negative impacts on placement outcome and carer longevity. Regarding number of child dependents, results suggest that services should consider the *total* number of children carers look after and how this may impact opportunities for positive caregiver responses. Schedule seven of the Children Act 1989 (Lord Chancellor's Department, 1989) stipulates that the "usual fostering limit" is three children though states that in the case of siblings, more than three children can be allocated to a carer. Although the act mentions the welfare of other children in the household, it does not specifically give guidance on how many non-fostered children may live alongside fostered. Further research using a larger sample of carers and observational methods is necessary to establish robustly the impact of multiple children on carers and carer-child interactions. If our findings are substantiated this could have an impact on the guidelines around the total numbers of children foster carers are able to care for. Future longitudinal research may also identify the long-term impact of caring for multiple children, informing services about short and long-term care decisions. As carer emotional distress and number of child dependents accounted for a modest proportion of the variance (16.4% and 6.2%, respectively), this highlights the need to explore other factors relevant to carer responsiveness. It would also be important to control for additional factors which could influence carer burden, such as economic context, social and professional support, and whether they care alone or as part of a partnership. There may be other factors that also influence carer responsiveness to children such as the number and type of training programmes they have undertaken, which unfortunately this study could not ascertain.

Conclusion

This study adds to the foster care literature, demonstrating links between carer emotional distress, total number of child dependents, and responsiveness to child distress. Results suggest that carer ER does not significantly relate to either carer distress nor carer responsiveness. Findings support the need for services to prioritise and promote carer well-being, as we know the impact can be harmful for carers, children and the caring profession. In addition, services need to consider the total number of children a carer is

responsible for, including the non-fostered children in their household. Further research is needed to explore other factors that may influence these links, and this could involve a larger sample size, more controlling for bias, and observational accounts in addition to self-report.

References

Bariola, E., Gullone, E., & Hughes, E. K. (2011). Child and adolescent emotion regulation: The role of parental emotion regulation and expression. *Clinical child and family psychology review, 14*(2), 198.

Bariola, E., Hughes, E. K., & Gullone, E. (2012). Relationships between parent and child emotion regulation strategy use: A brief report. *Journal of Child and Family Studies, 21*(3), 443-448.

Belsky, J. (1984). The determinants of parenting: A process model. *Child development, 55*(1), 83-96.

Blake, D. D., Weathers, F. W., Nagy, L. M., Kaloupek, D. G., Gusman, F. D., Charney, D. S., & Keane, T. M. (1995). The development of a clinician-administered PTSD scale. *Journal of traumatic stress, 8*(1), 75-90.

Blythe, S. L., Wilkes, L., & Halcomb, E. J. (2014). The foster carer's experience: An integrative review. *Collegian, 21*(1), 21-32.

Bowlby, J. (1988). *A Secure Base: Parent-Child Attachment and Healthy Human Development*. New York: Basic Books.

Brown, R., & Ward, H. (2013). *Decision-making within a child's timeframe: An overview of current research evidence for family justice professionals concerning child development and the impact of maltreatment*. London: Childhood Wellbeing Research Centre, Institute of Education.

Chamberlain, P., Price, J. M., Reid, J. B., Landsverk, J., Fisher, P. A., & Stoolmiller, M. (2006). Who disrupts from placement in foster and kinship care? *Child abuse & neglect, 30*(4), 409-424.

Clarke, H. (2009). *The age of foster care*. London, The Fostering Network.

Cole, P. M., Martin, S. E., & Dennis, T. A. (2004). Emotion regulation as a scientific construct: Methodological challenges and directions for child development research. Child Development, 75, 317–333.

Crittenden, P. M. (1983). The effect of mandatory protective daycare on mutual attachment in maltreating mother-infant dyads. *Child Abuse and Neglect, 7*, 297–300.

Denham, S. A., Bassett, H. H., & Wyatt, T. (2007). The socialization of emotional competence. *Handbook of socialization: Theory and research*, 614-637.

Department for Education (2017). *Children looked after in England (including adoption), year ending 31 March 2017 (SFR 50/2017)*. London: The National Archives.

Fabes, R., Eisenberg, N., & Bernzweig, J. (1990). *The coping with children's negative emotions scale: Procedures and scoring.* Available from authors. Metro Phoenix: Arizona State University.

Fabes, R. A., Poulin, R. E., Eisenberg, N., & Madden-Derdich, D. A. (2002). The Coping with Children's Negative Emotions Scale (CCNES): Psychometric properties and relations with children's emotional competence. *Marriage & Family Review, 34*(3-4), 285-310.

Farmer, E., Lipscombe, J., & Moyers, S. (2005). Foster carer strain and its impact on parenting and placement outcomes for adolescents. *British Journal of Social Work, 35*(2), 237-253.

Ford, T., Vostanis, P., Meltzer, H., & Goodman, R. (2007). Psychiatric disorder among British children looked after by local authorities: Comparison with children living in private households. *British Journal of Psychiatry, 190*(4), 319-325.

Gelman, A., Hill, J., & Yajima, M. (2012). Why we (usually) don't have to worry about multiple comparisons. *Journal of Research on Educational Effectiveness, 5*(2), 189-211.

Gibson, L. E., Anglin, D. M., Klugman, J. T., Reeves, L. E., Fineberg, A. M., Maxwell, S. D., ... & Ellman, L. M. (2014). Stress sensitivity mediates the relationship between traumatic life events and attenuated positive psychotic symptoms differentially by gender in a college population sample. *Journal of psychiatric research, 53*, 111-118.

Golding, K. (2003). Helping foster carers, helping children: Using attachment theory to guide practice. *Adoption & Fostering, 27*(2), 64-73.

Gray, M. J., Litz, B. T., Hsu, J. L., & Lombardo, T. W. (2004). Psychometric properties of the life events checklist. *Assessment, 11*(4), 330-341.

Gross, J. J. (2002). Emotion regulation: Affective, cognitive, and social consequences. *Psychophysiology, 39*(3), 281-291.

Gross, J. J., & John, O. P. (2003). Individual differences in two emotion regulation processes: implications for affect, relationships, and well-being. *Journal of personality and social psychology, 85*(2), 348-362.

Gross, J. J., & Levenson, R. W. (1993). Emotional suppression: physiology, self-report, and expressive behavior. *Journal of personality and social psychology, 64*(6), 970-986.

Harden, B. J. (2004). Safety and stability for foster children: A developmental perspective. *The future of children, 14*(1) 31-47.

Hayes, A. F. (2017). *Introduction to mediation, moderation, and conditional process analysis: A regression-based approach.* London: Guilford Press.

Healey, C. V., & Fisher, P. A. (2011). Young children in foster care and the development of favorable outcomes. *Children and youth services review, 33*(10), 1822-1830.

Henry, J. D., & Crawford, J. R. (2005). The short-form version of the Depression Anxiety Stress Scales (DASS-21): Construct validity and normative data in a large non-clinical sample. *British journal of clinical psychology, 44*(2), 227-239.

Hiller, R. M., & St. Clair, M. C. (2018). The emotional and behavioural symptom trajectories of children in long-term out-of-home care in an English local authority. *Child Abuse & Neglect, 81*, 106-117.

Horwitz, S. M., Balestracci, K. M., & Simms, M. D. (2001). Foster care placement improves children's functioning. *Archives of pediatrics & adolescent medicine, 155*(11), 1255-1260.

Howe, D., & Fearnley, S. (2003). Disorders of attachment in adopted and fostered children: Recognition and treatment. *Clinical Child Psychology and Psychiatry, 8*(3), 369-387.

Hughes, D., & Golding, K. (2012). *Creating loving attachments: Parenting with PACE to nurture confidence and security in the troubled child.* London: Jessica Kingsley Publishers.

Lamb, M. E., Gaensbauer, T. J., Malkin, C. M., & Schultz, L. A. (1985). The effects of child maltreatment on security of infant-adult attachment. *Infant Behavior and Development, 8*(1), 35-45.

Lawrence, C. R., Carlson, E. A., & Egeland, B. (2006). The impact of foster care on development. *Development and psychopathology, 18*(1), 57-76.

Linares, L. O., Montalto, D., Li, M., & Oza, V. S. (2006). A promising parenting intervention in foster care. *Journal of consulting and clinical psychology, 74*(1), 32-41.

Lipscombe, J., Moyers, S., & Farmer, E. (2004). What changes in 'parenting'approaches occur over the course of adolescent foster care placements? *Child & Family Social Work, 9*(4), 347-357.

Lord Chancellor's Department (1989). *Children Act.* London: The Stationery Office (TSO).

Macdonald, G., & Turner, W. (2005). An experiment in helping foster-carers manage challenging behaviour. *British Journal of Social Work, 35*(8), 1265-1282.

McCullough, E., Gordon-Jones, S., Last, A., Vaughan, J., & Burnell, A. (2016). An evaluation of Neuro-Physiological Psychotherapy: An integrative therapeutic approach to working with adopted children who have experienced early life trauma. *Clinical child psychology and psychiatry, 21*(4), 582-602.

McMillen, J. C., Zima, B.T., Scott Jr, L.D., Auslander, W. F., Munson, M. R., Ollie, M.T., & Spitznagel, E. L. (2005). Prevalence of psychiatric disorders among older youths in the foster care system. *Journal of the American Academy of Child & Adolescent Psychiatry, 44*(1), 88-95.

Menard, S. (1995). *Applied logistic regression analysis* (Sage University paper series on quantitative applications in the social sciences). Thousand Oaks, California: Sage Publications.

Moore, K. J., Osgood, D. W., Larzelere, R. E., & Chamberlain, P. (1994). Use of pooled time series in the study of naturally occurring clinical events and problem

behavior in a foster care setting. *Journal of consulting and clinical psychology, 62*(4), 718-728.

Morgan, K., & Baron, R. (2011). Challenging behaviour in looked after young people, feelings of parental self-efficacy and psychological well-being in foster carers. *Adoption & fostering, 35*(1), 18-32.

Morris, A. S., Silk, J. S., Steinberg, L., Myers, S. S., & Robinson, L. R. (2007). The Role of the Family Context in the Development of Emotion Regulation. *Soc Dev, 16*(2), 361-388.

Myers, R. H. (1990). *Classical and modern regression with applications* (Vol. 2). Belmont, CA: Duxbury Press.

Ofsted. (2018). *Fostering in England 2016 to 2017: main findings*. National Statistics. London: Ofsted.

Orme, J. G., & Buehler, C. (2001). Foster family characteristics and behavioral and emotional problems of foster children: A narrative review. *Family relations, 50*(1), 3-15.

Pickin, L., Brunsden, V., & Hill, R. (2011). Exploring the emotional experiences of foster carers using the photovoice technique. *Adoption & Fostering, 35*(2), 61-75.

Schofield, G., & Beek, M. (2005). Providing a secure base: Parenting children in long-term foster family care. *Attachment & human development, 7*(1), 3-26.

Selwyn, J., Wijedasa, D., & Meakings, S. (2014). *Beyond the Adoption Order: challenges, interventions and adoption disruption.* Research report. Bristol: University of Bristol, School for Policy Studies Hadley Centre for Adoption and Foster Care Studies.

Smith, D. K., Stormshak, E., Chamberlain, P., & Bridges Whaley, R. (2001). Placement disruption in treatment foster care. *Journal of emotional and behavioral disorders, 9*(3), 200-205.

Srivastava, S., Tamir, M., McGonigal, K. M., John, O. P., & Gross, J. J. (2009). The social costs of emotional suppression: A prospective study of the transition to college. *Journal of personality and social psychology, 96*(4), 883-897.

Timmer, S. G., Sedlar, G., & Urquiza, A. J. (2004). Challenging children in kin versus nonkin foster care: Perceived costs and benefits to caregivers. *Child Maltreatment, 9*(3), 251-262.

Topham, G. L., Hubbs-Tait, L., Rutledge, J. M., Page, M. C., Kennedy, T. S., Shriver, L. H., & Harrist, A. W. (2011). Parenting styles, parental response to child emotion, and family emotional responsiveness are related to child emotional eating. *Appetite, 56*(2), 261-264.

Twigg, R., & Swan, T. (2007). Inside the foster family: what research tells us about the experience of foster carers' children. *Adoption & Fostering, 31*(4), 49-61.

Webster-Stratton, C., & Reid, M. (2010). Adapting the Incredible Years, an evidence-based parenting programme, for families involved in the child welfare system. *Journal of Children's Services, 5*(1), 25-42.

Whenan, R., Oxlad, M., & Lushington, K. (2009). Factors associated with foster carer well-being, satisfaction and intention to continue providing out-of-home care. *Children and Youth Services Review, 31*(7), 752-760.

Blank page

Executive Summary

Lucy Armstrong

Department of Psychology, University of Bath

Lva21@bath.ac.uk

Word count: 583

Blank page

Executive summary

Background: There are currently around 53,420 children in foster care (Department for Education, 2017), making up the largest proportion of all children in care in the UK. Children who are fostered have often experienced negative and unpredictable emotional climates, leading them to become emotionally reactive and insecure (Cummings & Davies, 1996). In addition, looked after children are vulnerable to developing behavioural, social and psychological difficulties (Brown & Ward, 2013). The aim of foster care is to provide children with a secure environment where their risk of further trauma is minimised (Lawrence, Carlson, & Egeland, 2006). In addition, the attachment between carer and child is considered important for children to recover from the developmental and emotional harm they have experienced prior to entering care (Golding, 2003). Understanding factors that can contribute to secure attachments, such as the way in which carers interact and respond to children, is of high importance. Though we are aware that positive carer-child relationships are central to the success of placements and the longevity of careers in the profession, we know little about the factors that influence carer responsiveness. This study aimed to investigate whether carers' emotional distress, emotion regulation (ER) strategies, and their caregiver responsibilities (i.e., how many young people they care for) were associated with responsiveness to child distress. In addition, we looked at whether ER is associated with carer distress (depression, anxiety and stress) in order to understand how these factors interrelate.

Method: Eighty-six carers with a current foster child aged 4-12 years old, were recruited online and via posters advertising. This age range was chosen to fit with some of the item descriptions on one of our measures (Coping with Children's Negative Emotions Scale). Foster carers with multiple children were asked to complete scenario-based questions with only one foster child in mind, inviting them to think about the child with whom they have the most difficult relationship. Carers registered with both fostering services and private agencies were included and could take part irrespective of the type of care they provided (long term, short term, emergency, respite etc.). Participants were asked to complete an online questionnaire battery about their emotional distress (depression, anxiety, stress), ER strategies, caregiver response styles and various

characteristics associated with care. Participants were asked to choose a charity to select, and informed that a donation would be made on their behalf to thank them for their participation.

Results: Results found that carer distress and the total number of children in their household was associated with their responsiveness to child distress. That is, carers with higher levels of depression, anxiety and stress were less likely to show supportive (emotional and problem-focused) responses, and carers with more children to look after were less likely to encourage a distressed child to express themselves. Results remained significant after controlling for carer and child age. Carers' ER strategies were not significantly associated with their distress levels, nor their responsiveness to child distress.

Conclusion: This study adds to the foster care literature and highlights personal and placement factors that influence the care that foster children receive. Findings suggest the importance of supporting carer well-being both for the child and carers' benefit, and for the success of placements and the continued profession. In addition, results suggest that services need to consider the total number of children a carer is responsible for, including the non-fostered children in their household. Further research could help bolster these results with larger sample sizes, higher control for bias-reducing and by using observational methods alongside self-report.

Connecting Narrative

Lucy Armstrong

Department of Psychology, University of Bath

Lva21@bath.ac.uk

Word count: 2971

Blank page

Connecting Narrative

Prior to commencing the course I had had several years of research experience, working on different intervention trials in the UK and abroad, so felt this aspect was well within reach. The reality, it turned out, was much more complex and demanding than I imagined. From generating my own research questions within novel clinical areas, to juggling deadlines and course requirements to accomplish these, I would say that this component of the course was the most challenging and where I also learned a huge amount. This narrative piece details my journey within each research element, my regrets and celebrations.

Service Improvement Project (SIP)

When first introduced to the requirements of this project and with limited clinical experience in the NHS, I felt somewhat confused as to what exactly I might be able to "improve". I decided early on, in a fairly backward fashion, that I would focus my project on the one type of clinical work I had the most experience in – group interventions. After attending the research fair and gleaning some ideas I tried to take the efficient path of conducting my SIP during my older adult placement, which I began pursuing on my first day. As it turned out, trying to apply a project to an intervention group for Parkinson's which hadn't started running yet, wasn't going to work and this lent itself far more to evaluation than improvement. After a confronting PAS (project approval session) which reduced me to tears, I decided to scrap the project and start again, a decision I'm incredibly glad I made as this also wasn't an area of passion for me.

I quickly re-directed towards another group (Mindfulness) intervention being conducted locally to me and facilitated by two of the loveliest and most committed professionals I have ever met, Dr Helen Joannidi and Mr Michael Houser. Since I had previously facilitated, practiced and researched mindfulness this felt like a much more comfortable project and one that I cared deeply about. I quickly realised I did not know the literature as well as I had thought when I was taken under the wing of a new supervisor, Dr Liz Marks, who was highly knowledgeable about mindfulness. Liz was the ideal supervisor to have on this project as she not only was the embodiment of mindfulness and

an expert in the topic, she also got to know my external supervisors and the way they conduct their work.

Nevertheless, the project was not all smooth running. There were three major spokes in my wheel that significantly impacted progress. Firstly, passing the PAS process took a few attempts due to the need to shape it more to an "improvement" focus. There appears to be a fine line between what is considered an evaluation and improvement project, and I think I'm only still starting to understand where this is. Secondly, gaining ethical approval took an exceptionally long time considering only Trust R&D approval was necessary. Days before I submitted my application, the very helpful R&D professional I had been liaising with left her post. Over the next four months I waited until someone else had taken over and finally had access to the applications drive. During this time GDPR changes also came into place and my quantitative, pre- post- comparison aspect (also the "improvement" element to my project) needed to be scrapped. The service hadn't collected "opt in" consent for outcome measures over the past three years. This was highly disappointing for me and my supervisors. It took another couple of months to adjust my project to a purely qualitative design.

Thus begun my journey into Thematic Analysis, a messy yet fascinating and immersive process that had me picking coded post-it notes off my cats' feet for weeks to come. I enjoyed the data collection and write-up process a lot more than I imagined, particularly my phone interviews with group participants who really inspired my thinking. There was something uniquely frustrating and hugely satisfying about organising and re-organising themes and has made me keen to undertake qualitative research in the future.

Main research project

The area for my main research project was inspired by over a decade of discussing parenting practices with my mother, who taught attachment-informed courses to parents with young children. Early attachment experiences and the impact of childhood abuse and neglect have, as a result, always been of interest to me. I was then caught by an intriguing presentation about foster care services at our course Research Fair by Dr Sasha Walters, who would later become my external supervisor. It sounded so appealing to conduct research within a keen foster care service and with a supervisor who was so

knowledgeable and, as an ex-Bath trainee, informed about the requirements of the course. I felt this was the perfect project and felt really excited to go forward.

As I have learnt, some of the things that are incredibly fascinating are also overwhelmingly complex and tautological. This includes attachment theory. The next two years of my life on this project was spent drawing mediation diagrams and battling a headache. When it comes to the attachment relationships, emotions and behaviours of fostered children there are no linear lines to be drawn anywhere, which completed disrupted my preferred (but perhaps completely unrealistic) way of understanding the world and was the source of endless confusion. While I tussled with the theoretical links I was trying to explore, discarding one idea and picking up another, I felt exasperation coming from my research supervisor. This was too complicated. Another internal supervisor was brought in to help us figure a way through the mess and to help me pass my PAS.

This process took a year. It seemed that PAS supervisors were also confused as to the nature of my research question and in addition they specified the need for a non-correlational design. This requirement was problematic as it did not make sense for the research question and meant considering controversial group comparisons (e.g., foster vs. biological families), which my external research supervisor was not happy with. There was disagreement between my research supervisors and the research team, which added to confusion and delayed things more. It felt like I "just needed to pass" but that this task was also impossible. During this time, my external supervisor left the foster service she was in and the service declined to take part in the research. I was asked, with kind intent, whether I wanted to drop the project completely and switch to something else, but with the pressure of PAS I felt I had to keep going.

By the time the project passed PAS I was exhausted and had lost confidence in the project. Negotiating a way forward with now three supervisors was anxiety-provoking and I sometimes felt like I was being tested again on my unsteady ideas. The one silver lining to losing so much time was deciding to mainly recruit online, which meant avoiding potential bureaucracy of service and NHS ethics. It also made complete sense for the project, which now focused on foster carers' experiences, to advertise via Facebook, posters, and other social media platforms to acquire the most diverse sample.

Once recruitment was underway the write-up was mainly straight-forward, with the exception of conducting statistics. I wished I had been able to get more support with this, and I have subsequently taken these thoughts on to course staff and through the staff-student liaison committee. This was not an area of strength for me and at this time I felt I was getting the message that I "should be able to just get on with it" which did not improve my confidence.

Overall, this project has been a huge learning curve for me, the hardest aspect being developing a research question and a set of hypotheses. Though the project is now written up with some interesting results, I do wish I had taken the chance to switch to something else early on, considering the stress it involved alongside other demands of the course. The biggest lesson I can take away is to step back, take a breath and look at the bigger picture; if it just doesn't feel right don't push on. That, and the value of building confidence to ask for time and changes if needed.

Critical Review of Literature

My literature review has been a strange journey resulting in a very fortunate and enjoyable ending. The idea to do a review on voice-hearing came about after teaching on psychosis by Lorna Hogg and a speaker with voice-hearing experiences. I found this an incredibly eye-opening session, and it made me reflect on the people I had worked with pre-training with psychotic experiences. I approached Lorna and she agreed to supervise a project in this area. We met to explore ideas, but nothing seemed suitable for a literature review. As the deadline for submitting my PAS proposal grew closer, I found myself with one weekend to write it up and still no fixed idea. "Positive voice-hearing experiences" then emerged in a two-minute, panicked conversation with Lorna on the stairs of the department and I ran with it, allowing Lorna little time to check through my ideas. When the idea received a straight pass at my PAS I was overjoyed and a little arrogant; this was my first experience of PAS and it had been successful. I wondered what the worry related to PAS meetings had been about. I put aside the project for the next 18 months as I struggled through my main and SIP (see sections above).

When I next begun work on the project, Lorna simultaneously announced she was leaving the course. We decided it best to put work on hold until a new member of staff

joined the department and could supervise me. I was incredibly fortunate that my new supervisor, Dr Pamela Jacobsen, was highly knowledgeable and passionate about the topic, and was available for lengthy discussions early on. However, this was also now October of my second year, giving me six months to complete the project from start to finish. Due to delays in other projects and my late start on this one, I found myself quite nervous about what this "unknown creature" could turn out to be. In my first meeting with Pamela she identified that I didn't have a research question. This heightened my worry, however Pamela remained optimistic and encouraging. After one meeting we had decided on a question. I felt pressured but focused, and worked hard to make the most of our meetings and to gain progress quickly. My write-up and relevant queries seemed to flow easily, which felt like a case of luck or perhaps as a result of my positioning along the Yerkes-Dodson (1908) [1] curve at this pressured time. Looking back, I think that 18 months of writing up other projects, case studies and the extensive amount of academic reading I had done, was likely to have influenced my progress.

Overall, I have thoroughly enjoyed my literature review from start to finish and it has been an exciting and rewarding experience. One of the absolute highlights of this project has been the development of a "positive voice-hearing" framework which involved conversations with multiple professionals and voice-hearers who shared their experiences with me. I found these amongst the most profound conversations I've ever had, on one occasion being moved to tears by such open-hearted stories about relationships with voices. I am excited to present this review in Berlin at the World Congress of Behavioural and Cognitive Therapies, and I hope people will enjoy reading about it as much as I have enjoyed working on it.

---

[1] Yerkes, R. M., & Dodson, J. D. (1908). The relation of strength of stimulus to rapidity of habit-formation. *Journal of comparative neurology and psychology*, *18*(5), 459-482.

Case studies

Prior to the course I had never written a case study before and the idea of writing five was a daunting prospect. My experience of these has varied from placement to placement, with some more challenging than others. I learnt quite quickly that rather than trying to use and write up a perfect manualised-type intervention, case studies were more likely to involve writing up cases where I had done my best within the remits of my skills and the service. Although my adult mental health case study was my first, it was fairly straight-forward to write and since the intervention had led to positive changes, it gave me a boost of confidence that I probably needed at this early stage in training. The topic, using CBT in the context of adult offending behaviours, was also an area I was fascinated in which meant reading around the case study was interesting and motivating. I presented this case study as a poster at the BABCP conference in Glasgow in 2018, which was a very proud and rewarding few days for me and has made me keen to continue to write and disseminate clinical case work.

My older adult case study was far less simple to write-up and to get my head around, as it blended a CBT approach with Narrative Therapy elements, something that we hadn't yet learnt about in our systemic teaching. I was also under pressure to complete a single case experimental design, as I had not fulfilled this in my first placement. I had missed the timings to complete three baseline weekly measures, and following course guidance, introduced a daily idiosyncratic measure around fear of falls. As this was a rushed approach (I recall gaining instruction from a member of course staff in my car outside the client's home), there were inevitable problems. Firstly, the idiosyncratic questions my client and I devised could have been more meaningful if we had spent more time on this. Secondly, I felt guilty for asking this elderly lady to complete questions every day and it was as though I was taking advantage of her willingness for company. This latter point I have somewhat come to terms with, as I have become more used to integrating outcome measures with therapy and realise that client don't often mind completing these as much as we regret asking them to.

Case studies in my Child and Adolescent and Learning Disabilities placements were also somewhat difficult to complete. This was mainly due to the way in which clinical work had progressed, rather than the difficulty of writing per se. In both cases, I

used straight-forward CBT interventions, for low self-esteem and social anxiety respectively. However, both were adolescent clients who presented as reserved, shy and acquiescing which made it difficult to know how they genuinely felt and whether they were happy with the intervention and associated measures. Although I had other clients who presented in similar ways in these services, it felt very different and much more pressured to be completing a written piece of work alongside the intervention. Again, time has been useful for reflecting on this and I recognise that my feelings may also be tied up in the lack of significant improvement made in both pieces of work. I can now acknowledge my efforts to make sessions as collaborative as possible, and I believe these clients benefitted overall from our time together.

My final case study involved the use of family therapy for a couple in secondary mental health services and was written to comply with both doctorate training and systemic intermediate course requirements. Although my experience with clients was limited by having only completed four sessions, this was an interesting case to write up. I was able to draw on issues of diversity, family systems and multiple perspectives more explicitly than I had done previously, which I believe has developed my systemic thinking. For my corrections, I was asked to reflect more on my own position in relation to the couple I was seeing and the issues I encountered in this case. Although this is something I did during the piece of work, it felt more difficult than I predicted to write these down and submit them. For me this highlights the need for more integrated systemic thinking and reflection time within the course.

Overall, writing case studies has been an interesting and valuable aspect of the course. I am glad I chose to write up a range of cases, conditions and approaches as this has really deepened my understandings of these. It has also encouraged me to reflect on the use of outcome measures, creating and testing hypotheses, collaborative decision-making and structuring therapy sessions (or at least attempting to). In terms of write up, I initially felt somewhat fraudulent when trying to fill the evidence-based gaps in what I had done, adding in this information after the fact. However, in hindsight all my clinical decisions had emerged through conversations with clinical supervisors, teaching, materials used by services, and clients (for the most part) were involved and engaged with the approaches taken. This case study component, along with my developing clinical

skills, has helped me to make links between what I am doing and why. It has also helped me to recognise that making these links don't always involve something novel and clever; this has solidified my pre-training experiences and taught me to trust in the knowledge I have been acquiring over the course of training.

Conclusion

My research experiences on the course have been a combination of highs and lows, resulting in both success and burnout. I have learned a great deal over three years about setting up projects, choosing research questions that make sense, applying for ethics and recruiting. When my understanding was clear, and I had supportive supervision, I really enjoyed writing up my projects. I have been proud of my writing ability and I believe this skilled has been well honed on the course. I am also glad to have developed in confidence about how to present my ideas, ask questions and ask for support. I will continue to take these lessons forward and I hope to enjoy a clinical career that involves research.

Acknowledgements

With sincere thanks to the course staff who supervised my research and supported me, along with my ideas, through the course: Dr Liz Marks, Dr Pamela Jacobsen, Lorna Hogg, Dr Catherine Hamilton-Giachritsis, Dr Rachel Hiller, and Dr Jo Daniels. I am especially grateful to Liz and to Pamela, who went beyond their supervisor roles to encourage and inspire me in our meetings.

Thank you to my regional research supervisors, Dr Helen Joannidi, Michael Houser, Dr Sasha Walters, and Dr Samantha Green for your support and persistence, including from afar. Thank you also to my placement supervisors, who taught me so much and helped me to reflect on my journey. In particular, Dr Jade West, whose patience and kindness set me off on the right foot, and to Sam whose humour and compassion relighted my enthusiasm after a difficult time.

To the service-users who have given time and energy to contribute to my research projects, to feed back their honest thoughts while I developed my ideas, and those who helped me to develop as a clinician, thank you. I have learned my biggest lessons from you.

My fellow trainees, cohort 2016, you have been the most fantastic cheerleaders and human-beings to have had alongside me on this journey. Thank you for being there to laugh, cry, whinge, dance, and now celebrate with.

To my family and friends I thank you for being there, for giving me perspective and keeping me resilient. Thanks to mum especially for the long phone conversations and for your delightful “care packages” of chocolates and flowers that kept me going.

Finally, the biggest thanks of all goes to my wonderful fiancé Laurence, whose support I could not have done without. I feel incredibly lucky to have had your love, patience and caring throughout the last three years, and I am so excited to marry you in 2020.

Appendices

Appendix 1a: PRISMA systematic review checklist

Section/topic	#	Checklist item	Reported on page #
TITLE			
Title	1	Identify the report as a systematic review, meta-analysis, or both.	13
ABSTRACT			
Structured summary	2	Provide a structured summary including, as applicable: background; objectives; data sources; study eligibility criteria, participants, and interventions; study appraisal and synthesis methods; results; limitations; conclusions and implications of key findings; systematic review registration number.	9
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of what is already known.	15-17
Objectives	4	Provide an explicit statement of questions being addressed with reference to participants, interventions, comparisons, outcomes, and study design (PICOS).	N/A
METHODS			
Protocol and registration	5	Indicate if a review protocol exists, if and where it can be accessed (e.g., Web address), and, if available, provide registration information including registration number.	18
Eligibility criteria	6	Specify study characteristics (e.g., PICOS, length of follow-up) and report characteristics (e.g., years considered, language, publication status) used as criteria for eligibility, giving rationale.	18-19
Information sources	7	Describe all information sources (e.g., databases with dates of coverage, contact with study authors to identify additional studies) in the search and date last searched.	19
Search	8	Present full electronic search strategy for at least one database, including any limits used, such that it could be repeated.	Appendix 1b
Study selection	9	State the process for selecting studies (i.e., screening, eligibility, included in systematic review, and, if applicable, included in the meta-analysis).	19-20

Data collection process	10	Describe method of data extraction from reports (e.g., piloted forms, independently, in duplicate) and any processes for obtaining and confirming data from investigators.	19-21
Data items	11	List and define all variables for which data were sought (e.g., PICOS, funding sources) and any assumptions and simplifications made.	19-21
Risk of bias in individual studies	12	Describe methods used for assessing risk of bias of individual studies (including specification of whether this was done at the study or outcome level), and how this information is to be used in any data synthesis.	N/A
Summary measures	13	State the principal summary measures (e.g., risk ratio, difference in means).	N/A
Synthesis of results	14	Describe the methods of handling data and combining results of studies, if done, including measures of consistency (e.g., I^2) for each meta-analysis.	19-21

Section/topic	#	Checklist item	Reported on page #
Risk of bias across studies	15	Specify any assessment of risk of bias that may affect the cumulative evidence (e.g., publication bias, selective reporting within studies).	N/A
Additional analyses	16	Describe methods of additional analyses (e.g., sensitivity or subgroup analyses, meta-regression), if done, indicating which were pre-specified.	N/A
RESULTS			
Study selection	17	Give numbers of studies screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally with a flow diagram.	20
Study characteristics	18	For each study, present characteristics for which data were extracted (e.g., study size, PICOS, follow-up period) and provide the citations.	22-34
Risk of bias within studies	19	Present data on risk of bias of each study and, if available, any outcome level assessment (see item 12).	N/A
Results of individual studies	20	For all outcomes considered (benefits or harms), present, for each study: (a) simple summary data for each intervention group (b) effect estimates and confidence intervals, ideally with a forest plot.	N/A
Synthesis of results	21	Present results of each meta-analysis done, including confidence intervals and measures of consistency.	N/A
Risk of bias across studies	22	Present results of any assessment of risk of bias across studies (see Item 15).	N/A

Additional analysis	23	Give results of additional analyses, if done (e.g., sensitivity or subgroup analyses, meta-regression [see Item 16]).	N/A
DISCUSSION			
Summary of evidence	24	Summarize the main findings including the strength of evidence for each main outcome; consider their relevance to key groups (e.g., healthcare providers, users, and policy makers).	33
Limitations	25	Discuss limitations at study and outcome level (e.g., risk of bias), and at review-level (e.g., incomplete retrieval of identified research, reporting bias).	36-38
Conclusions	26	Provide a general interpretation of the results in the context of other evidence, and implications for future research.	38-40
FUNDING			
Funding	27	Describe sources of funding for the systematic review and other support (e.g., supply of data); role of funders for the systematic review.	N/A

From: Moher, Liberati, Tetzlaff, Altman, & Group, 2009

For more information, visit: **www.prisma-statement.org**.

Appendix 1b: Search strategy for PubMed and Medline

Search strategy used in Pubmed:

Pubmed website: https://www.ncbi.nlm.nih.gov/pubmed/advanced

Search **((((voice-hear*[Title/Abstract] OR auditory hallucinations[Title/Abstract])) AND (instrument[Title/Abstract] OR measure[Title/Abstract] OR scale[Title/Abstract] OR interview[Title/Abstract]))) AND ("2009/12/01"[Date - Publication] : "2019/02/16"[Date - Publication])**

Search strategy used in PsycInfo/PsycTESTS:

APA PsycNet website (https://psycnet.apa.org/search)

Abstract: voice-hear* *OR* **Abstract**: auditory hallucinations *AND***Abstract**: instrument *OR* **Abstract**: measure *OR* **Abstract**: scale *OR* **Abstract**: interview *AND* **Year**: 2009 *To* 9999

Following search select "PsycInfo" and "PsycTESTS" results

Appendix 1c: Table of scale items within each positive category of Voice-Hearing (VH)

Category	Items (subcategory, number, description and scale)
Relationship with/ identity of voice	**CONTROLLABILITY/POWER/SUPERIORITY:** 26. I am in control of my inner speech (VISQ-R) 31. Option 1. The subject believes that he/she can control the voices and make them appear or disappear when he/she wants (PSAS) 11. Controllability of voices (Subject believes they can have control over the voices and can always bring on or dismiss them at will (PSYRATS-AH) 3) During the last 24 hours, how in control of your "voices" do you feel? (Totally)- CAHQ 1. I am more/much more powerful than my voice (VPD) 2. I am stronger/much stronger than my voice (VPD) 3. I am confident/much more confident than my voice (VPD) 4.My voice respects me more/much more than I respect it (VPD) 6. I am superior/greatly superior to my voice (VPD) 7. I am more knowledgeable/much more knowledgeable than my voice (VPD) **COMMUNICATING WITH VOICE**: 6. When I speak or converse with the voice, I say nice things (DAIMON) 7. When I speak or convers with the voice, I tell it things that are amusing and funny (DAIMON) 23. The voices talk to each other, [saying] nice things about me or the people in my environment (DAIMON) **CLOSENESS/COMPANIONSHIP:** 31a. When the voices stopped, or if they were to stop, did you, or do you think you'd ever miss them? (MUPS) 31b. Is there some sort of relationship between you and the voice(s)? (MUPS) 5. Companionship: Does the voice keep you company when you're lonely? (RSPH) 2. Controlled: If you could control when the voice came and when it didn't, would you want to be able to hear it sometimes? (RSPH) REPLICATED: 4. Some people find some pleasure or comfort in the voices (e.g., they laugh at your jokes, make you feel special, or keep you company). Is there a positive part of hearing voices for you? AHIG **INSPIRATION/GUIDE:** 27. I listen to it because I want to (BAVQ/R) 6) I have a tendency to look up to my voice (VAY)
Beliefs/ own identity as voice-hearer	8. Personality/character (positive impact on) (SEPS) 28. Sense of personal identity (positive impact on) (SEPS) 8. My voice is helping me to develop my special powers or abilities (BAVQ/R) 4. Self-concept: Does hearing voices affect the way you feel about yourself? How you compare to others? Special? (RSPH)
Function/intention of voice	**ENCOURAGING/PLEASANT/FRIENDLY:** 19. I talk to myself silently in an encouraging way (VISQ-R)

Category	Items (subcategory, number, description and scale)
	22. I think to myself in the second person, saying things like “You can do this” or “You forgot to do that” (VISQ-R) 4. Some people find some pleasure or comfort in the voices (e.g., they laugh at your jokes, make you feel special, or keep you company). Is there a positive part of hearing voices for you? (AHIG) 12. Content (sub-items): Verb: What was the action within the hallucination vis-a-vis the patient? (action was reduced to three categories including "positive"), Reaction: What was the patient's attitude to such action? (answers gradings include 1-"pleasure, comfort, reassurance" and 2-"interest" (PCH) 9. Typically, are the voices hostile or friendly or different at different times? (AHIG) 15. Friendliness (CCAH) 12. Tone of voice: In your last illness episode in which you heard the voices, would you say the tone of the predominant voice(s) was generally: (ratings include "gentle", "loving", "kind" and "friendly") (MUPS) 37. How much of the time have your experiences been pleasant? (SEPS) Item 3. Do you ever hear pleasant voices? (UVS) **HEALTHY IMPACT:** 5. Levels of energy (positive impact on) (SEPS) 10. Amount and/or quality of sleep (positive impact on) (SEPS) 6. My voice is helping to keep me sane (BAVQ/R) 19. I look after my health, eat good food, get enough sleep, exercise and try to stay cheerful. – RAHQ PROTECTIVE: 6. Defensive: Does the voice* protect you from uncomfortable situations or feelings? Does it warn you of danger? (RSPH) **ENHANCES PERFORMANCE/HELPFUL:** A12. When my voices say things, I accept what is helpful and reject what is not (VAAS-12 only) 14. Concentration (positive impact on) (SEPS) 21. Memory (positive impact on) (SEPS) 1. Ability to socialise (SEPS) 19. Ability to control your own thoughts (SEPS) 17. Ability to find work (e.g. paid or voluntary) (SEPS) 2. My voice wants to help me (BAVQ/R) 2) My voice helps me make up my mind (VAY) 12. When my voices say things, I accept what is helpful and reject what is not (VAAS) 18. I talk with the voices or listen to what they are saying – they may be helpful. (RAHQ) 8. Performance: When the voice* comes while you're working on something, does it affect your ability to work? Does it make the work harder or easier? (RSPH) 11. Sexual: Does the voice* interfere with/enhance your sexual interest/activity? (RSPH) 22. Content of voices: Select one or more of the cards that you think best describe(s) the content of the voices you heard in your last illness episode (i.e. what the voices were about), or create new ones if you would like, that may provide a better description. Ratings include: "helpful", "guiding", "affirming", and "inspiring". (MUPS)

Category	Items (subcategory, number, description and scale)
	ENTERTAINING: 25. The voices speak talk to each other, about topics that interest me and I want to be informed (DAIMON) 26. The voices speak talk to each other, [about] funny topics that make me laugh and are fun (DAIMON)
Emotional impact of VH	**CALM/COMFORTED/REASSURED:** 27. I calm myself down by talking silently to myself (VISQ-R) 32. When angry, my inner speech can help calm me down (VISQ-R) 19. My voice makes me feel calm (BAVQ/R) 13. Please rate your mood as it is now (ratings include "very calm"/"fairly calm" (TVRS) 3. Self-soothing: Is there anything comforting about that voice*? (RSPH) 5) During the last 24 hours, how is the tone of your “voices”? (very comforting) (CAHQ) 14. My voice reassures me (BAVQ/R) 8. These voices are (ratings including "fairly comforting"/"very comforting") (TVRS) **EXCITED/HAPPY/CHEERFUL:** Item 30. My train of inner verbal thought can lead to me feeling very excited (VISQ-R) 16. My voice makes me happy (BAVQ/R) 14. Please rate your mood as it is now (ratings include "very cheerful"/"fairly cheerful" (TVRS) 32. In your last illness episode in which you heard the voices/sounds, can you describe how you felt when the predominant voice(s)/sounds were with you? Ratings include "comforted", "not alone anymore", "reassured", "excited", "inspired", "happy" (MUPS) 11. Ability to enjoy hobbies and/or activities (SEPS) **EMPOWERED:** 16. Feelings of empowerment (positive impact on) (SEPS) 21. My voice makes me feel confident (BAVQ/R) 22. Your feelings of control over any experiences you may have (positive impact on) (SEPS) **REDUCTION IN NEGATIVE AFFECT:** 4. Levels of anxiety and stress (positive impact on) (SEPS) 12. Feelings of isolation (positive impact on) (SEPS) 15. Level of depression (SEPS) 23. Levels of embarrassment (positive impact on) (SEPS) 27. Feelings of vulnerability (positive impact on) (SEPS) 29. Amount of anger and frustration (positive impact on) (SEPS) 18. Worries over your financial situation (positive impact on) (SEPS) 13. Concerns about becoming unwell (positive impact on) (SEPS) 35. When I think to myself in words about upsetting things, I can easily change topics in my mind and talk to myself about other things (VISQ-R) EMOTIONAL CONNECTION: 26. Ability to feel emotion (positive impact on) (SEPS)

Category	Items (subcategory, number, description and scale)
Meaning-making of VH experiences	**CONNECTION TO OTHERS:** 2. Ability to trust others (SEPS) 3. Relationship with friends and loved ones (positive impact on) (SEPS) 25. Feelings of discrimination or being judged (SEPS) **OUTLOOK:** 9. Motivation to change any experiences you may have (SEPS) 40. How much have you viewed having your experiences as positive? (SEPS) 7. Hope for the future (positive impact on) (SEPS) 24. Feelings about your freedom and personal right (SEPS) 20. Ability to cope with everyday life (SEPS) 10. My voice is helping me to achieve my goal in life (BAVQ/R) 12. I am grateful for my voice (BAVQ/R) 23b. Is it possible that the idea behind the message/content of the voices is linked or connected to someone who is or was influential in your life? (MUPS) General: Would you rather keep on hearing the voice* or have it go away? (RSPH)

*Wording changed from generic "psychotic experiences" to voice-related. Measures: SAPS=Scale for Assessment of Positive Symptoms. PANSS=Positive and Negative Syndrome Scale. MUPS=Mental Health Research Institute Unusual Perceptions Schedule. BAVQ/R= Beliefs About Voices Questionnaire/Revised. PSYRATS-AH= Psychotic Symptom Rating Scales-Auditory Hallucinations. VPD=Voice Power Differential. CAHQ=Characteristics of Auditory Hallucinations Questionnaire. AHRS=Auditory Hallucinations Rating Scale. RAHQ=Responses to Auditory Hallucinations Questionnaire. SMVQ= Southampton Mindfulness of Voices Questionnaire. VAAS=Voices Acceptance and Action Scale. HPSVQ=Hamilton Program for Schizophrenia Voices Questionnaire. VAY=Voice and You Scale. UVS=Unpleasant Voices Scale. SEPS=Subjective Experiences of Psychosis Scale. APSS=Adolescent Psychotic-like Symptom Screener. VISQ/R=Varieties of Inner Speech Questionnaire/Revised. PaSI=Panic and Schizophrenia Interview. SSI=Schizotypal Symptoms Inventory. PSAS=Psycho-Sensory hAllucinations Scale. VAAS=Voices Acceptance and Action Scale. AHIG=Auditory Hallucinations Interview Guide. MUSEQ=Multi-modality Unusual Sensory Experiences Questionnaire. CAHSA=Continuum of Auditory Hallucinations-State Assessment.

Appendix 1d: Table of Voice-Hearing (VH) measures with number of scale items relevant to positive experiences categories

Study	Scale	Positive relationship to voice	Positive beliefs/ identity about self	Positive function/ intention of voice	Positive emotional impact of VH	Positive meaning-making from VH experiences
Lowe, 1973	Phenomenologic characteristics of hallucinations.			1		
Hustig et al., 1990	Topography of voices rating scale				3	
Miller et al., 1993	Rating scale for phenomenology of hallucinations*	2	1	3	1	1
Carter et al., 1995	MUPS	2		2	1	1
Chadwick et al., 1995	BAVQ	1	1	3	3	2
Oulis et al., 1995	Clinical characteristics of auditory hallucinations*			1		
Haddock et al., 1999	PSYRATS-AH	1				
Birchwood et al., 2000	VPD	6				
Chadwick et al., 2000	BAVQ-R	(1)	(1)	(3)	(3)	(2)
Trygstad et al., 2002	CAHQ	1			1	
Mann et al., 2006	RAHQ			2		
Shawyer et al., 2007	VAAS			1		
Van Lieshout et al., 2007	HPSVQ					
Hayward et al., 2008	VAY	1		1		
Gerlock et al., 2010	UVS/ HCSP				1	
Haddock et al., 2011	SEPS		2	9	12	8
de Chazeron et al., 2015	PSAS	1				
Brockman et al., 2015	VAAS-12			(1)		
Perona-Garcelán et al., 2015	DAIMON	3		2		
Trygstad et al., 2015	AHIG	1		2		
Alderson-Day et al., 2018	VISQ-R	1		2	4	
Total number of items related to each positive category		**20**	**4**	**29**	**26**	**12**

*Scale items not available, results are estimations based on measure descriptions or “sample” items. Brackets indicate repeated items in revised measures; these have not been included in category total. Measures: SAPS=Scale for Assessment of Positive Symptoms. PANSS=Positive and Negative Syndrome Scale. MUPS=Mental Health Research Institute Unusual Perceptions Schedule. BAVQ/R= Beliefs About Voices Questionnaire/Revised. PSYRATS-AH= Psychotic Symptom Rating Scales-Auditory Hallucinations. VPD=Voice Power Differential. CAHQ=Characteristics of Auditory Hallucinations Questionnaire. AHRS=Auditory Hallucinations Rating Scale. RAHQ=Responses to Auditory Hallucinations Questionnaire. SMVQ= Southampton Mindfulness of Voices Questionnaire. VAAS=Voices Acceptance and Action Scale. HPSVQ=Hamilton Program for Schizophrenia Voices Questionnaire. VAY=Voice and You Scale. UVS/HCSP=Unpleasant Voices Scale & Harm Command Safety Protocol. SEPS=Subjective Experiences of Psychosis Scale. APSS=Adolescent Psychotic-like Symptom Screener. VISQ/R=Varieties of Inner Speech Questionnaire/Revised. PaSI=Panic and Schizophrenia Interview. SSI=Schizotypal Symptoms Inventory. PSAS=Psycho-Sensory hAllucinations Scale. VAAS=Voices Acceptance and Action Scale. AHIG=Auditory Hallucinations Interview Guide. MUSEQ=Multi-modality Unusual Sensory Experiences Questionnaire. CAHSA=Continuum of Auditory Hallucinations-State Assessment.

Appendix 1e: Instructions for authors (*Schizophrenia Bulletin)*

Manuscripts submitted to *Schizophrenia Bulletin* should be prepared following the *American Medical Association Manual of Style*, 10th edition. The manuscript text (including tables) should be prepared using a word processing program and saved as an .rtf or .doc file. Other file formats will not be accepted. Figures must be saved as individual .tif files and should be numbered consecutively (i.e., Figure 1.tif, Figure 2.tif, etc.). The text must be double-spaced throughout and should consist of the sections described below.

Manuscript Length

Manuscripts should be concisely worded and should not exceed 5,000 words for major reviews, 4,000 words for regular articles, or 2,500 words for invited special features. The word count should include the abstract, text body, figure legends, and acknowledgments and must appear together with the abstract word count on the title page of the manuscript. Supplementary data, including additional methods, results, tables, or figures will be published online.

Abstract

Provide a summary of NO MORE THAN 250 WORDS describing why and how the study, analysis, or review was done, a summary of the essential results, and what the authors have concluded from the data. The abstract should not contain unexplained abbreviations. Up to six key words that do not appear as part of the title should be provided at the end of the abstract.

Main Text

Unsolicited original manuscripts reporting novel experimental findings should be comprised of these sections, in this order: Abstract, Introduction, Methods, Results, Discussion, Acknowledgments, References, and Figure Legends. Review articles must contain an abstract; however, the body of the text can be organized in a less structured format. Authors of review articles are encouraged to use section headers to improve the readability of their manuscript.

Number pages consecutively beginning with the title page. Spelling should conform to that used in *Merriam-Webster's Collegiate Dictionary* , eleventh edition. Clinical laboratory data may be expressed in conventional rather than Système International (SI) units.

References

Authors are encouraged to be circumspect in compiling the reference section of their manuscripts.
Please note: references to other articles appearing in the same issue of the journal must be cited fully in the reference list.

Each reference should be cited in consecutive numerical order using superscript arabic numerals, and reference style should follow the recommendations in the *American Medical Association Manual of Style* , 10th edition, with one exception: in the reference list, the name of all authors should be given unless there are more than 6, in which case the names of the first 3 authors are used, followed by "et al."

Figures and Tables

Full length manuscripts including regular and invited theme articles should contain no more than a combined total of 5 tables and figures. Theme introductions and special features are limited to 2 tables or figures (total). Figures and tables must be referred to using arabic

numbers in order of their appearance in the text (e.g., Figure 1, Figure 2, Table 1, Table 2, etc.).

Tables should be created with the table function of a word processing program; spreadsheets are not acceptable. Include only essential data, and format the table in a manner in which it should appear in the text. Each table must fit on a single manuscript page and have a short title that is self-explanatory without reference to the text. Footnotes can be used to explain any symbols or abbreviations appearing in the table. Do not duplicate data in tables and figures.

Please be aware that the figure requirements for initial online submission (peer review) and for reproduction in the journal are different. Initially, it is preferred to embed your figures within the word processing file or upload them separately as low-resolution images (.jpg, .tif, or .gif files). However, upon submission of a revised manuscript, you will be required to supply high-resolution .tif files for reproduction in the journal (1200 d.p.i. for line drawings and 300 d.p.i. for color and half-tone artwork). It is advisable to create high-resolution images first as these can be easily converted into low-resolution images for online submission. Figure legends should be typed separately from the figures in the main text document. Additional information on preparing your figures for publication can be located athttp://cpc.cadmus.com/da .

Wherever possible figures should be submitted in their desired final size, to fit the width of a single (88 mm) or at most a double (180 mm) column width. All letters and numerals appearing in a particular figure should be of the same size and in proportion to the overall dimensions of the drawing. Letter labels used in figures should be in upper case in both the figure and the legend. The journal reserves the right to reduce the size of illustrative material.

Supplementary Material

Supporting material that is not essential for inclusion in the full text of the manuscript, but would nevertheless benefit the reader, can be made available by the publisher as online-only content, linked to the online manuscript. The material should not be essential to understanding the conclusions of the paper, but should contain data that is additional or complementary and directly relevant to the article content. Such information might include more detailed methods, extended data sets/data analysis, or additional figures (including color). It is standard practice for appendices to be made available online-only as supplementary material. All text and figures must be provided in separate files from the manuscript files labeled as supplementary material in suitable electronic formats (instructions for the preparation of supplementary material can be viewed here).

All material to be considered as supplementary material must be submitted at the same time as the main manuscript for peer review. It cannot be altered or replaced after the paper has been accepted for publication. Please indicate clearly the material intended as supplementary material upon submission. Also ensure that the supplementary material is referred to in the main manuscript where necessary.

Appendix 2a: Telephone consent form

University of Bath
Department of Psychology
Tel: 01225 38 3251
Researcher: Lucy Armstrong
Lva21@bath.ac.uk

TELEPHONE CONSENT FORM

Exploring and improving mindfulness practice (and related outcomes) in an integrated *Mindful Life* group

I…… (insert name), facilitator of the Mindful Life group confirm that the following service user has given verbal consent to be contacted by the researcher, Lucy Armstrong, for the above project:

Name of service user……..

Contact number……

Postal address ……

……

……

Email address (if preferable for contact purposes)……

I can confirm that the above service user has been given the following information about the project:

We are contacting you because you attended the Mindful Life group in [give date]. We want to ask whether you would be happy to take part in a research project which is aiming to evaluate and improve the group. This would involve a conversation with an external researcher to give your opinions and feedback about your experience of the group, and your answers would be completely anonymous even to [give other facilitator's name] and me. The researcher is a Clinical Psychologist in training at the University of Bath who also works in mental health in the NHS. She has some questions that she would like to ask several people who have attended the group and this should only take 20-30 minutes. This could be over the phone at a time that is convenient for you, or if you would prefer you could meet in person. It is completely up to you if you would like to take part, and if you choose not to this won't impact on your care now or in the future. If you are happy to take part, the next step would be to pass your details to Lucy Armstrong (the researcher) so she can contact you and send you some more information.

Signature…… Date……

Appendix 2b: Cover letter for participants

Department of Psychology
10 West, University of Bath
Claverton Down
Bath, BA2 7AY
Email: Lva21@bath.ac.uk
Phone: [redacted]

DATE

RE: Participation in *Mindful Life* group Service Improvement Project

Dear [name of participant],

I hope this letter finds you well.

Thank you for chatting recently to Hen/Michael over the phone, and for showing an interest in my project.

I have enclosed information about the project. I am interested in finding out about your experience of the Mindful Life group and hope that you will be happy to have a phone conversation with me for 20-30 minutes, at a time that suits. If you prefer we could alternatively meet in person. You do not need to have completed the group or attended every session.

Please take a look at the information and you can contact me with any questions and to let me know if you're happy to take part. Your help and feedback are very appreciated, and there are no right or wrong answers. Your current and future care will not be affected AT ALL based on whether you decide to take part or not.

If you would rather go through this information over the phone, please let me know by calling or emailing using the details above.

Kind regards,

Lucy Armstrong

Clinical Psychologist in Training

University of Bath

Appendix 2c: Participant information form

Project: Exploring and improving mindfulness practice (and related outcomes) in an integrated *Mindful Life* group

Participant Information Sheet

Overview

I am inviting you to take part in a short telephone or face-to-face conversation about your experience of the *Mindful Life* group run at Blackberry Hill Hospital or Kingswood Civic Centre. It is known that mindfulness groups can lead to a wide range of benefits, and these are sometimes related to practice. The group has been running for over three years but has never been evaluated. We hope that by gathering feedback from people who have attended the group we will be able to improve the service for others in the future. It is up to you to decide whether to take part and your care will not be affected by your choice.

Before you decide to take part, it is important that you understand what the research involves and why we are doing it. Please take the time to read the following information carefully and discuss it with others if you wish. Please ask if there is anything that is not clear or if you need more information.

Please let me know if you would like to go through this information over the phone.

What is this evaluation about?

The *Mindful Life* group aims to introduce mindfulness to people of different ages and from different services. I would like to collect feedback from 6-10 individuals with a mixture of backgrounds who have attended the group in the last 12 months. In this feedback conversation I will ask you questions about your experience of the group, with a particular focus on meditation *practice* both within the group and at home. You do not have to have attended every session. Your feedback is very valuable to making improvements for future groups.

Who is conducting the research?

The evaluation is being conducted by Lucy Armstrong, a Clinical Psychologist in Training at the Department of Psychology at the University of Bath. I am conducting this evaluation as part of my doctoral research portfolio in collaboration with Avon & Wiltshire Mental Health Partnership NHS Trust, which your service belongs to. The evaluation has been approved by the Department of Psychology Ethics Committee at the University of Bath and the Research & Development Department at AWP.

What will I need to do?

I would like to call you at a time that suits, about your experience in the group. This call will last about 20-30 minutes, and this is a one-off conversation so we will not need to contact you again after this. You will only need to answer the questions you are happy to answer. I will send you the questions in advance so you have time to remember and reflect on your experience before we speak. There are no right or wrong answers as I am interested in individual experiences of the group. Alternatively, if you would prefer to have the conversation in person we could make arrangements for this. If you do choose this option, you will be reimbursed for your travel costs. I will be audio-recording the conversation as I will need to listen to it and type it up later.

It is up to you to decide whether you would like to take part. If you decide to take part, you will be asked to sign a consent form. After this you are still free to change your mind and remove your data at any time, without giving a reason.

What are the possible benefits of taking part?

The evaluation gives you a chance to discuss your experience of the Mindful Life Group and the results will be used to improve future groups for future clients. Unfortunately we are not able to pay you for taking part.

What are the possible disadvantages or risks of taking part?

We do not see many disadvantages or risks of taking part in the evaluation. However, you may find it distressing to discuss your experiences of any difficulties that you may have encountered before or during the Mindful Life group. If this happens, you can stop the conversation or decline to answer any questions. We can suggest people to contact for support. If necessary we will help you contact your GP or call them directly so they can offer you support.

How will my information be kept confidential?

If you decide to take part, the conversation will be recorded. The audio recording will be kept securely on a computer and protected so that nobody else can access it. The data will then be typed up with all identifiable details removed. Any typing service which assists with this process will be bound by confidentiality. The recordings will not be available for others to hear, although anonymised parts of the conversation may be used when writing up the results. The recording will be destroyed after the project has been completed. Only the researcher (Lucy Armstrong) and the academic supervisor (Dr Elizabeth Marks) will have access to the recording. NONE of the facilitators of the *Mindful Life* group will hear the recordings.

After the project has finished, the University of Bath will keep only the anonymous typed conversations for up to 10 years, and not the audio recordings. This data may be used for other research but no other researchers would have access to your personal details.

What will happen to the results of this research?

The results of this evaluation will be fed back to facilitators of the group, Hen Joannidi and Michael Houser (but they will not know how you personally answered questions in the interview). The results will be used to make recommendations about how to best improve the *Mindful Life* group so that people can get the most out of mindfulness both during during and after the group. The findings of the research may be published in a research journal or presented at a conference. If you are interested in the results we can send these to you; this would be sometime in 2019.

What if there is a problem?

If you have any concerns or wish to complain about any aspect of this project, you should initially contact the researcher, Lucy Armstrong or Dr Elizabeth Marks who will do their best to address your concerns. Their contact details are provided below. If you remain unhappy and wish to complain formally, you can do this by contacting, the University of Bath Psychology Department Research Executive Officer, Dr. Nathalia Gjersoe at psychology-ethics@bath.ac.uk or by phone on 01225 38 4322.

For any further queries about consent, data storage or anything else, please contact the main researcher, Lucy Armstrong on:

Email – Lva21@bath.ac.uk **Phone –** [redacted]

Address: Lucy Armstrong, Clinical Psychologist in Training, Department of Psychology, 10 West, University of Bath, Claverton Down, Bath, BA2 7AY

For any further enquiries related to your care, you can contact Hen Joannadi or Michael Houser on 0117 378 4640

If you have any additional questions or concerns, please contact Dr Elizabeth Marks, Academic Supervisor at the University of Bath on: E.Marks@bath.ac.uk

Thank you for taking the time to read this information sheet. If you would like to continue with the project, please complete and return the enclosed consent form which could be by email or post. If you could do this before the date we are due to speak that would be much appreciated.

Appendix 2d: Consent form

CONSENT FORM

Title of Project: Exploring and improving mindfulness practice (and related outcomes) in an integrated Mindful Life group

Please initial box

1. I confirm that I have read the information sheet dated Tuesday 6th February 2018 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to change my mind and remove my data at any time without giving any reason, without my medical care or legal rights being affected. ☐

3. I understand that other researchers at the University of Bath may use my data for other research purposes, but they will not have access to my name or other details about me. The data will be stored for up to 10 years. ☐

4. I agree to my General Practitioner being informed if any issues related to risk arise whilst participation in the study. ☐

5. I agree to take part in the above study. ☐

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of Person taking consent	Date	Signature

Appendix 2e: Interview schedule

Mindful Life SIP

"Thank you for agreeing to take part in the interview today. We have 20-30 minutes for the interview, so I will try to move through the questions with this in mind. I'm interested in getting your perspective of the Mindful Life group. There are no right or wrong answers. Feel free to just speak about what you've noticed during and after the group. This interview is confidential, and group facilitators will not be told what individual interviewees have said".

Topic 1: General experience

1. To start, when did you take part in the Mindful Life group and which location did you attend?
2. How many times did you attend the group?
3. Which service were you referred from (adult PTS, later life, psychosis, memory)?

Topic 2: Group practice

4. The sessions involved doing a number of different meditation practices in and outside of the group. Are there particular practices you remember doing IN the group?

   Prompt: (List different practices _ Body Scan, Movement, Sitting meditation…..)

5. How would you describe your experience of these practices within the group?
   Prompt: (good/bad/enjoyable/useful/not useful/difficult/easy)?

   Prompt: Could you expand on this for me?

Topic 3: Home practice

6. The group also required you to try doing different meditation practices at home, between the group sessions. Did you practise mindfulness at home? How much? How did you find the home practice?
   Prompt: (good/bad/enjoyable/useful/not useful/difficult/easy)?

   Prompt: Are there particular practices you remember doing, for example XXX?

7. Did anything help you to do more practise at home? Did anything get in the way of practising at home?
   Prompt: Time, space, motivation, support from CDs / other materials.

8. How important do you think home practice is in terms of helping you to develop your mindfulness skills and in terms of seeing things change in your life and self? Prompt: Why did you think this?

Topic 4: Improvement

9. How did you find the balance in the group between discussion and meditation practice? Would you have wanted this to change at all? How and Why?
   Prompt: More time practising mindfulness in the sessions, less time discussion, or vice versa

10. Did the group facilitators present the home practice as important? What could have been done differently to encourage/explain mindfulness practice at home?

11. Some people have suggested that certain changes may have helped them to understand or practise more at home. What do you think about the following suggestions and why:

    - The facilitators spend more time explaining practice and its importance

    -Being asked to keep practice diaries

    -Spending more time discussing home practice and what you learnt each week

    -Spending more time exploring barriers and supporters of practice to help you find ways to practise more

Topic 5: Overall impact and continued practice

12. Are you practising mindfulness now? If not, why not? If so, why?

13. Finally, is there anything else that you think is important to mention about the group?

Appendix 2f: Debriefing information

UNIVERSITY OF BATH

Debriefing Information

Thank you for taking part in this project which has been exploring the experiences of people who have completed the Mindful Life group at either Blackberry Hill Hospital or Kingswood Civic Centre, Bristol.

This project involves questions about the effect that mindfulness and the group has had on you, and for some people this means thinking about the negative life experiences that led them to take part in the group. If you have found this distressing in any way, it may be useful to contact your care coordinator within the Trust or your GP, if you are no longer under the care of this service.

Thank you again for participating. If you would like to speak to us about the project please get in touch.

Lucy Armstrong, researcher

Email – Lva21@bath.ac.uk **Phone –** [redacted]

Hen Joannidi/ Michael Houser, Mindful Life group facilitators

Email - helenjoannidi@nhs.net Phone- 0117 378 4640
michael.houser@nhs.net

You can also speak to the supervisor of the project, Dr Elizabeth Marks

Email – E.Marks@bath.ac.uk Phone – 01225 384 051

Our address is: Department of Psychology, University of Bath, Claverton Down Bath, BA2 7AY

Appendix 2g: Ethical approval (University of Bath and NHS trust)

NHS
Avon and Wiltshire Mental Health Partnership
NHS Trust

Lucy Armstrong

By secure email:
lucy.armstrong1@nhs.net

Avon and Wiltshire Mental Health Partnership AWP Trust
R&D Department
Fromeside- East Wing
Manor Road
Fishponds
BS16 2EW

0117 378 4217

Date 16/04/18

Dear Lucy,

Exploring and improving mindfulness practice (and related outcomes) in an integrated *Mindful Life* group

AWP Reference: E2018.002

This letter is to confirm that your evaluation is now approved and also provides you with our reference number.

If you do need any further support or information, please contact us using the contact details above, quoting our reference number for your study.

The importance of disseminating all evaluation work cannot be over emphasised. It is only by sharing our learning that we can improve services across AWP. For this reason, the findings of all evaluation work should be reported to the Evaluation team via email. The team will champion the results of service evaluations, and work with evaluators to ensure those results are disseminated and acted upon, and that the results of evaluations are reflected in future service delivery. The team will also work with evaluators to produce publications for the public domain.

Please also remember that all service evaluation work must be represented as such in future publications or presentations.

I very much look forward to receiving the results of your evaluation in due course.

Yours sincerely,

Dr Julian Walker
R&D Director, AWP

On Tue, Jun 19, 2018 at 10:15 AM +0100, "Nathalia Gjersoe" <N.Gjersoe@bath.ac.uk> wrote:
Dear Lucy,

Thank you for letting us know about these amendments. I am happy to confirm that you have received full ethical approval, via Chair's Action. Your file will be updated to include these changes.

Best of luck with your research,
Dr. Nathalia Gjersoe
Chair, Psychology Ethics Committee

On Mon, Jun 11, 2018 at 10:28 AM +0100, "Nathalia Gjersoe" <N.Gjersoe@bath.ac.uk> wrote:

Dear Lucy,

Thank you for letting us know about this amendment. I am happy to confirm that you have received full ethical approval, via Chair's Action. Your file will be updated to include these changes.

Please use your ethics code in the subject line of any future correspondence regarding this project.

Best of luck with your research,
Dr. Nathalia Gjersoe
Chair, Psychology Ethics Committee

From: psychology-ethics
Sent: Wednesday, 14 February, 10:33
Subject: Ethics 18-018 Approved
To: Lucy Armstrong
Cc: Elizabeth Marks

Dear Lucy,
Thank you for taking the time to make these amendments and clarifications. I am happy to confirm that you have full ethical approval for this amended application. Please use the code 18-018 as proof of ethical approval on all internal documents.

Best of luck with your research,
Dr. Nathalia Gjersoe
Chair, Psychology Ethics Committee

From: psychology-ethics
Sent: 08 February 2018 11:45
To: Lucy Armstrong
Cc: Elizabeth Marks
Subject: Ethics 18-018 Conditional Approval

Dear Lucy

Ethics 18-018: How can practice elements of the Mindful Life group be adapted to improve overall effectiveness for future groups?
The ethics committee have considered your application for the study above and have given it conditional ethical approval.

The committee have raised the following points which they would like you to attend to before resubmitting a new application for approval:

- Please provide written confirmation (email will suffice) from Trust R&D confirming agreement for audit and service evaluation to be carried out (this can be on the basis of ethical approval being granted by University of Bath ethics department).
- Sampling: You state that you might set a quota of participants from each service and potentially exclude participants from more responsive services when data saturation is reached. Please explain the process by which you will identify and exclude participants prior to consenting to take part.
- Cover letter: You state "It will not affect your current or future care AT ALL if you do decide to take part." Please amend to include any decision made by the participant *not* to take part.
- Information sheet: "The study has been approved by the Department of Psychology and AWP Research & Development" – please make it clear that you are referring to the University of Bath department of psychology ethics committee as well as R&D; Also please make it clear how participants can ask for results to be sent to them ("If you are interested in the results we can send these to you).
- Interview schedule: In the introduction speech please make sure you mention that you can stop the recording at any time; please also state that the interview may take between 20-30 minutes if this is anticipated to ensure expectations are suitably managed.
- Please confirm that you do not intend to collect any demographic information about participants. If you do please provide details.

It is not a condition of ethical approval, but the committee has also raised the following methodological issues which you may like to consider:

- It might be a good idea, if you haven't already, to pilot the interview schedule with a person with experience to ensure you have an accurate estimate of time and to check for any glitches.
- Data storage – you state in the information sheet that transcripts will be kept for up to 3 years, but in your application you say up to 10 years. Please ensure that you are consistent with details in your data management plan.
- Check interview schedule for typos

Please reply to this email with the required information. Please follow the instructions on the Psychology Ethics Moodle page to do this:

All amendments must be noted on the application form and highlighted in yellow,
The amended ethics application should be attached to your response
The ethics code should be preserved in the subject line of the email and
Your cover email should detail how you have responded to each point.

Yours sincerely,
Dr. Nathalia Gjersoe
Chair, Psychology Ethics Committee

Appendix 2h: Instructions for authors (*Mindfulness, Springer US)*

Permissions
Authors wishing to include figures, tables, or text passages that have already been published elsewhere are required to obtain permission from the copyright owner(s) for both the print and online format and to include evidence that such permission has been granted when submitting their papers. Any material received without such evidence will be assumed to originate from the authors.

Abstract
Please provide of structured abstract of up to 250 words
Keywords
Please provide 4 to 6 keywords which can be used for indexing purposes.
Text Formatting
Manuscripts should be submitted in Word.
Use a normal, plain font (e.g., 10-point Times Roman) for text.
Use italics for emphasis.
Use the automatic page numbering function to number the pages.
Do not use field functions.
Use tab stops or other commands for indents, not the space bar.
Use the table function, not spreadsheets, to make tables.

Headings
Please use no more than three levels of displayed headings.

Abbreviations
Abbreviations should be defined at first mention and used consistently thereafter.

Citation
Cite references in the text by name and year in parentheses. Some examples:
Negotiation research spans many disciplines (Thompson 1990).
This result was later contradicted by Becker and Seligman (1996).
This effect has been widely studied (Abbott 1991; Barakat et al. 1995; Kelso and Smith 1998; Medvec et al. 1999).
Reference list
The list of references should only include works that are cited in the text and that have been published or accepted for publication. Personal communications and unpublished works should only be mentioned in the text. Do not use footnotes or endnotes as a substitute for a reference list.
Reference list entries should be alphabetized by the last names of the first author of each work.

Tables
All tables are to be numbered using Arabic numerals.
Tables should always be cited in text in consecutive numerical order.
For each table, please supply a table caption (title) explaining the components of the table.

Quotes
A search for other qualitative papers within the journal found an example of in-text quotations presented in the following way:

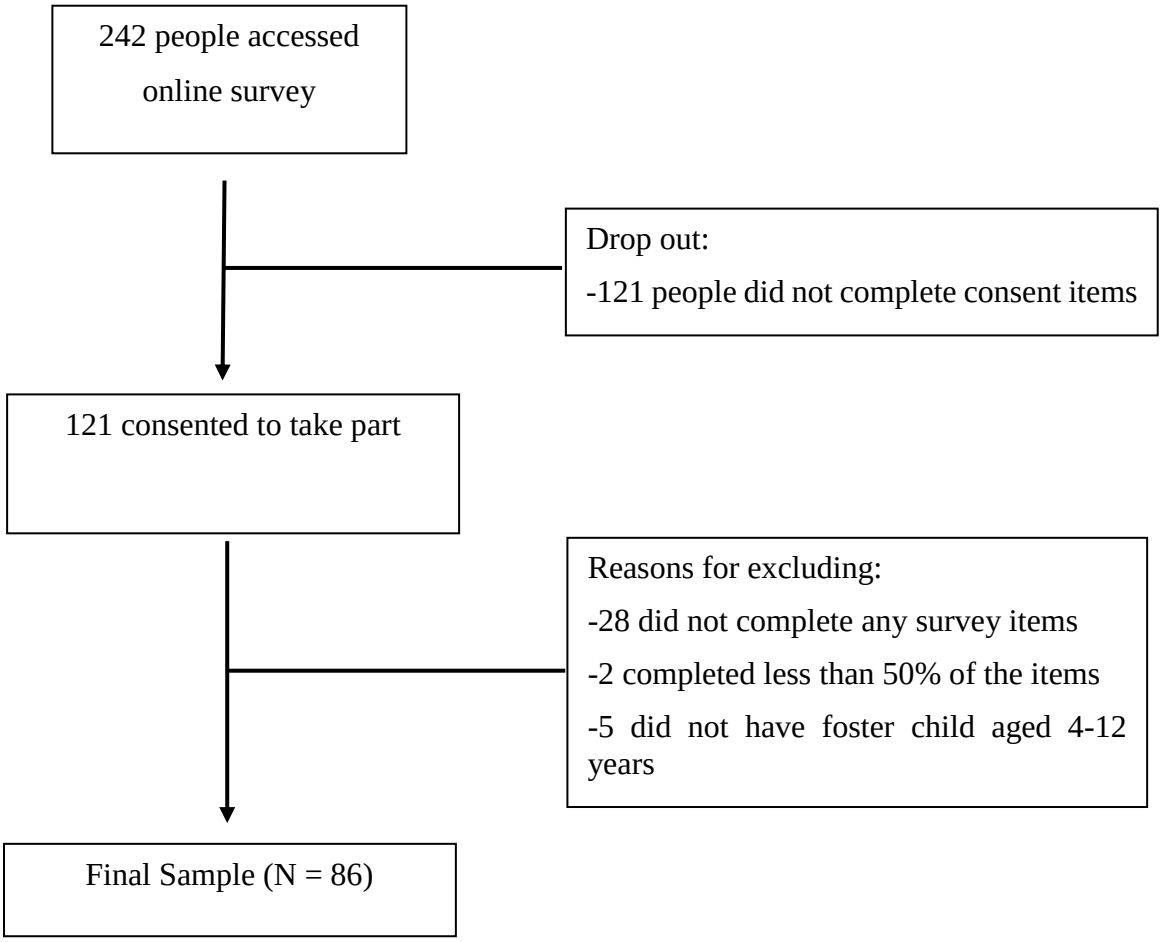
"This theme facilitated engagement as it seemed participants were already considering engaging with the intervention before it had started. For example,

> "My job is so stressful; I felt I needed to learn it (mindfulness) so I could reduce my stress" (Sarah).

Prior Knowledge

Participants' comments reflected that positive feedback and promising research findings had an impact in facilitating engagement in the intervention.

Appendix 3a: Flowchart for Main Research Project recruitment.



Appendix 3b: Break down of foster carers' responses to child distress using middle score split

	High adaptive responses (i.e., validates and encourages expression, uses emotion and problem-focused strategies; score > 4.5)	Low adaptive responses (i.e., validates and encourages expression, uses emotion and problem-focused strategies; score < 4.5)
High maladaptive responses (i.e., punitive and minimising; score > 4.5)	e.g. carers who are expressive using both supportive and maladaptive responses (n = 0)	e.g. carers who offer limited support and encouragement, with punitive/dismissive responses (n = 0)
Low maladaptive responses (i.e., punitive and minimising; score < 4.5)	e.g. highly adaptive carers who use few maladaptive strategies and are very supportive and encouraging (n = 80)	e.g. carers who do not respond in maladaptive ways, but do offer limited validation and expressive encouragement (n = 4)

Appendix 3c: Spearman's Rho correlation matrix for associations (r_s) between main variables.

	1. Expressive encourage-ment	2. Supportive Responses	3. Non-support ive Responses	4. Depress-ion	5. Anxiety	6. Stress	7. Expressive Suppression	8. Cognitive Reappraisal	9. Length of place-ment	10. Number of child dependents	11. Time in profession	12. Carer age
Carer responsiveness												
1. Expressive Encouragement												
2. Supportive Responses	.392**											
3. Non-supportive Responses	-.257*	-.179										
Carer emotional distress												
4. Depression	-.089	-.294*	.115									
5. Anxiety	-.027	-.315**	.066	.721**								
6. Stress	-.155	-.390**	.105	.749**	.673**							
Emotion Regulation												
7. Expressive Suppression	-.090	-.031	.238	-.006	.050	.007						
8. Cognitive Reappraisal	-.074	.111	-.088	-.064	-.115	-.161	-.010					
Factors related to care/ carer												
9. Length of placement	.081	-.096	-.034	-.009	-.110	-.039	.046	-.216				
10. Number of child dependents	-.422**	-.193	.199	.148	.199	.168	.102	-.273*	-.093			
11. Time in profession	-.069	.174	-.188	-.079	-.143	-.076	.122	-.149	.363**	.158		
12. Carer age	.052	.305**	-.167	.147	-.021	-.029	.067	-.062	.160	-.123	.424**	
13. Child age	.186	.025	-.232*	.108	.009	.096	-.015	-.176	.340**	-.270*	.136	.280*

**p<0.01, *p<0.05

Appendix 3d: Ethical approval from the University of Bath (emails)

From: Nathalia Gjersoe
Sent: 22 May 2018 14:58
To: Lucy Armstrong
Subject: RE: Ethics 18-122 further amendments

Dear Lucy,

Thank you for letting us know about these amendments. I am happy to confirm that you have received full ethical approval, via Chair's Action. Your file will be updated to include these changes.

Best of luck with your research,

Dr. Nathalia Gjersoe

Chair, Psychology Ethics Committee

From: psychology-ethics
Sent: 08 May 2018 16:16
To: Lucy Armstrong
Subject: Ethics 18-122 Approved

Dear Lucy,

Thank you for taking the time to make these amendments and clarifications. I am happy to confirm that you have full ethical approval for this amended application. Please use the code 18-122 as proof of ethical approval on all internal documentation.

Best of luck with your research,

Dr. Nathalia Gjersoe

Chair, Psychology Ethics Committee

From: psychology-ethics
Sent: 04 May 2018 10:03
To: Lucy Armstrong
Cc: Catherine Hamilton-Giachritsis
Subject: Ethics 18-122 Conditional Approval

Dear Lucy Armstrong,

Ethics [18-122] [Examining the influence of fostering on carer experience and wellbeing.]

The ethics committee have considered your application for the study above and have given it conditional ethical approval.

The committee have raised the following points which they would like you to attend to before resubmitting a new application for approval:

- Please include a screening procedure to the consent form (e.g., using tick boxes) to ensure those not eligible to participate do not complete the whole study.
- Please add contact details for psychology ethics committee to debrief sheet
- Please include the participant information sheet (PIS) and recruitment advert to the revised submission, making clear the type of document it is.

Please reply to this email with the required information. Please follow the instructions on the Psychology Ethics Moodle page to do this:

All amendments must be noted on the application form and highlighted in yellow,
The amended ethics application should be attached to your response
The ethics code should be preserved in the subject line of the email and
Your cover email should detail how you have responded to each point.

Yours sincerely,

Dr. Nathalia Gjersoe
Chair, Psychology Ethics Committee

Appendix 3e: Poster advertisement for the study

RESEARCHING FOSTER CARE & WELL-BEING

UNIVERSITY OF BATH

FOSTER CARERS NEEDED FOR ONLINE RESEARCH SURVEY!

My name is Lucy Armstrong. I am a Clinical Psychologist in Training. I would like to invite you to participate in a research study.

The study is about challenges that foster carers face, how they manage their emotions and how they respond to children in their care.

We are looking for:

- Foster carers with at least one year's experience of caring for a looked after child, and with a child aged 4-12 years currently in your care

The study involves completing an online survey which will take approximately 30 minutes. **The survey is completely anonymous!** If you would prefer to complete paper forms, please contact me directly (details at the bottom of this poster).

We are hoping to build our knowledge of foster carers' experience and mental well-being so that services can better support them. We know that higher carer resilience means positive care for children, and carers' ability to continue to offer high quality placements over a longer period.

By taking part in the project you will be able to select a charity of your choice and researchers will make a donation on your behalf.

For more information and to complete the survey please go to: https://bathpsychology.eu.qualtrics.com/jfe/form/SV_82DrV8sTpLpKpOB. We are also on Facebook and Twitter (@fosterresearch)

Email: Lva21@bath.ac.uk This study has been approved by the University of Bath Ethics Committee. Reference no. 18-122

Appendix 3f: Information sheet for the study

Version: 20th May 2018

Project: Examining the influence of fostering on carer experience and wellbeing.

Participant Information Sheet

Overview

I am inviting you to take part in a short questionnaire survey about you and your experience caring for foster children. It is known that foster carers play a significant role in the recovery and development of children who have experienced maltreatment. While being a carer can be very rewarding, we also know that this work can be highly challenging and stressful, which can understandably bring up difficult feelings for carers.

Research shows that the way we manage our emotions (called Emotion Regulation) can influence our mood and levels of stress, and that stress can also impact the way that we then respond to others. We are interested in finding out more about how these things link together for foster carers, and if individuals could benefit from more support around managing emotions. We hope that by gathering responses from carers like you we will be able to improve services and support for others in the future. **It is up to you to decide whether to take part and your current support will not be affected by your choice.**

Before you decide to take part, it is important that you understand what the research involves and why we are doing it. Please take the time to read the following information carefully and discuss it with others if you wish. Please contact me if there is anything that is not clear or if you need more information.

Who can participate?

Participants are any foster carer who currently has at least 1 foster child in their care, aged between 4 and 12 years old. Carers looking after more than one child are welcome to take part, but they will only be asked about one of the children in their care.

What does participating involve?

This is a questionnaire-based study, so you can complete the research online from wherever is convenient. If you would prefer, questionnaires can be posted to you and you can return at no cost to you. If you would like to receive the questionnaire pack via post

please just email the lead researcher, using the contact details at the end of this information.

Questionnaires will take around 30 minutes to complete, and you will not be asked to give your name or any identifiable details. The questionnaires ask about how you are feeling currently (e.g., your current levels of stress or anxiety), how you manage emotions, any stressful past life events and how you respond to children in your care when they are displaying difficult emotions or behaviours. It is important to note that there are no right or wrong answers. However, it is important to answer with what you are actually thinking/doing rather than what you *think* you should be doing. **As this study is anonymous your responses will have no impact of your current services or care arrangements.**

Your responses are very valuable to building knowledge about foster care issues, and for making future improvements to services.

Who is conducting the research?

The study is being conducted by Lucy Armstrong, a Clinical Psychologist in Training at the Department of Psychology at the University of Bath. I am conducting this study as part of my doctoral research portfolio. I am supervised by Dr Catherine Hamilton-Giachritsis and Dr Rachel Hiller, also at the University of Bath, as well as Dr Sasha Walters (external supervisor). The study has been approved by the Department of Psychology Ethics Committee at the University of Bath.

Do I have to take part?

No. This is a completely voluntary study, so it is up to you to decide whether you would like to take part. If you do take part, you are also free to skip any questions that you do not wish to answer. After participating, if you decide that you want to withdraw your data from the study, you can do so by contacting the researchers any time up to 1 March 2019.

What are the possible benefits of taking part?

The study gives you a chance to record your feelings and experience as a foster carer, and the results will be used to inform knowledge and potential future support for other carers. Unfortunately we are not able to pay you for taking part. However, as a thank you for your time, a donation will be made on your behalf, and you will also be able to choose a charity from our list to receive this.

What are the possible disadvantages or risks of taking part?

We do not see many disadvantages or risks of taking part in the study. However, you may find it distressing to record your feelings and experiences. If this happens, you can stop the questionnaire or skip over any questions. At the end of the questionnaire pack we have suggestions about who you can call if you are feeling distressed. Of course, if any of these questions make you feel distressed, we would encourage you to speak to your supervising social worker.

How will my information be kept confidential?

If completing questionnaires online or in paper format, we will not ask for your name or which service you belong to. **No information can therefore be passed back to the foster care agency/service that you belong to, so your responses will NOT have any impact on your current or future work.**

The non-identifiable data will be kept securely on a computer. You will be given a password for your data, so that your data can be found if you choose to withdraw it from the study, after your participation.

After the study has finished, the University of Bath will keep your anonymous questionnaire data for up to 10 years, as per standard data management policy and as required by the British Psychological Society. If you consent to it, the data that you've given may be used for other research and the University of Bath will ensure that any other research also goes through approval stages in the same way as this one. To be clear, you can consent to take part in the study but not consent to have your data available to others in the future.

What will happen to the results of this research?

The results of the overall study will be used to inform understandings of foster carer experience and may be used in future to make decisions about support offered by services. The findings of the research may be published in a research journal or presented at a conference. If you are interested in the results of the study you are welcome to contact the researchers and we can send these to you; this would be sometime in 2019.

What if there is a problem?

If you have any concerns or wish to complain about any aspect of this project, you should initially contact the researcher, Lucy Armstrong or Dr Catherine Hamilton-Giachritsis or Rachel Hiller who will do their best to address your concerns. Their contact details are provided below. If you remain unhappy and wish to complain formally, you can do this by contacting, the University of Bath Psychology Department Research Executive Officer, Dr. Nathalia Gjersoe at psychology-ethics@bath.ac.uk or by phone on 01225 38 4322.

Version: 20th May 2018

For any further queries about consent, data storage or anything else, please contact the main researcher

Name: Lucy Armstrong

Email: Lva21@bath.ac.uk

Postal Address: Lucy Armstrong, Clinical Psychologist in Training, Department of Psychology, 10 West, University of Bath, Claverton Down, Bath, BA2 7AY

If you have any additional questions or concerns, please contact Dr Catherine Hamilton-Giachritsis, Academic Supervisor at the University of Bath on: C.Hamilton-Giachritsis@bath.ac.uk

Or Dr Rachel Hiller: R.Hiller@bath.ac.uk

Thank you for taking the time to read this information. If you would like to continue with the study, please read and agree to the consent information on the next page, and then you will be able to answer questionnaires. If you would like to complete these on paper, please contact the researcher (Lucy Armstrong) by using the contact details above. You can then complete and return consent and questionnaire forms by post using a pre-paid envelope which we will send you.

If you do not wish to participate you can simply exit the program now.

Appendix 3g: Consent form

University of Bath
Department of Psychology
Tel: 01225 38 3251
Researcher: Lucy Armstrong
Lva21@bath.ac.uk

Participant Identification Number for this study:

CONSENT FORM

Title of Project: Examining the influence of fostering on carer experience and wellbeing.

Please initial box

1. I confirm that I am currently a foster carer with at least one year of experience in the profession. ☐
2. I confirm that I care for at least one child aged 4-12 years, and I will be answering questions with reference to this one child. ☐
3. I confirm that I have read the information sheet dated 20th May 2018 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
4. I understand that my participation is voluntary and that I am free to change my mind and remove my data by 1 March 2019 (when the data will be analysed) without giving any reason, without my access to services or legal rights being affected. ☐
5. I consent to my data being re-used by researchers at the University of Bath for other research purposes, but they will not have access to my name or other details about me. The data will be stored for up to 10 years, as required by the British Psychological Society. ☐
6. I agree to take part in the above study. ☐

Appendix 3h: Demographic questions

Version: 20th May 2018

Demographic Information

1. Please circle if you are male, female or other (please give detail): _____
2. What is your age? _____
3. What is your ethnicity? _____
4. Are you are currently connected to a foster service/ agency (please circle)?
5. What kind of foster care do you offer (please circle)? Short term/ long term placements/ other (please give detail): _____
6. How many years have you been working in foster care? _____
7. Have you completed any training courses related to providing care for young people? Please circle: Yes/ no. If yes please give details: _____

   _____
8. How many children (total) are <u>currently</u> in your care? _____
9. Of this total, how many are fostered? _____

Please think of a child currently in your care, aged between 4-12 years. If you care for more than one child, please focus on <u>one</u> child with whom you have the most difficult relationship.

We would like you to keep this child in mind for the following questions and over the next few pages.

10. How old is this child? _____
11. For how long has the child been in your care?

    _____ years_____months

Appendix 3i: Measures

COPING WITH CHILDREN'S NEGATIVE EMOTIONS SCALE (CCNES)[1]

Purpose: To measure the degree to which parents perceive themselves as reactive to young children's (preschool through early elementary school) negative affect in distressful situations. Six subscales are derived that reflect the specific types of coping response parents tend to use in these situations.

SUBSCALES

1. **Distress Reactions (DR).** These items reflect the degree to which parents experience distress when children express negative affect.

Scoring: Mean of: 1B, 2A*, 3A, 4D, 5E, 6C, 7C*, 8C*, 9B, 10A*, 11B, 12D.

* = REVERSED SCORING

2. **Punitive Reactions (PR).** These items reflect the degree to which parents respond with punitive reactions that decrease their exposure or need to deal with the negative emotions of their children.

Scoring: Mean of: 1A, 2F, 3F, 4A, 5D, 6D, 7E, 8E, 9E, 10B, 11C, 12E.

3. **Expressive Encouragement (EE).** These items reflect the degree to which parents encourage children to express negative affect or the degree to which they validate child's negative emotional states (i.e., "it's ok to feel sad.")

Scoring: Mean of: 1E, 2E, 3E, 4B, 5F, 6E, 7F, 8A, 9A, 10C, 11F, 12B.

4. **Emotion-Focused Reactions (EFR).** These items reflect the degree to which parents respond with strategies that are designed to help the child feel better (i.e., oriented towards affecting the child's negative feelings).

Scoring: Mean of: 1F, 2B, 3D, 4E, 5A, 6A, 7B, 8F, 9F, 10D, 11E, 12C.

5. **Problem-Focused Reactions (PFR).** These items reflect the degree to which parents help the child solve the problem that caused the child's distress (i.e., oriented towards helping the child solve his/her problem or coping with a stressor).

Scoring: Mean of: 1C, 2D, 3C, 4F, 5B, 6F, 7A, 8B, 9D, 10E, 11D, 12A.

6. **Minimization Reactions (MR).** These items reflect the degree to which parents minimize the serious of the situation or devalue the child's problem or distressful reaction.

Scoring: Mean of: 1D, 2C, 3B, 4C, 5C, 6B, 7D, 8D, 9C, 10F, 11A, 12F.

[1]**Please cite as follows: Fabes, R.A., Eisenberg, N., & Bernzweig, J. (1990). The Coping with Childre Negative Emotions Scale: Procedures and scoring. Available from authors. Arizona State Universit**

Address correspondence to Richard Fabes, Department of Family Resources and Human Developme Arizona State University, Tempe, AZ, 85287-2502.

ID _____

Parent Attitude/Behavior Questionnaire

Instructions: In the following items, please indicate on a scale from 1 (very unlikely) to 7 (very likely) the likelihood that you would respond in the ways listed for each item. Please read each item carefully and respond as honestly and sincerely as you can. For each response, please circle a number from 1-7.

Response Scale: 1 2 3 4 5 6 7
Very Unlikely Medium Very Likely

---

1. If my child becomes angry because he/she is sick or hurt and can't go to his/her friend's birthday party, I would:

a. send my child to his/her room to cool off 1 2 3 4 5 6 7
b. get angry at my child 1 2 3 4 5 6 7
c. help my child think about ways that he/she can still be with friends (e.g., invite some friends over after the party) 1 2 3 4 5 6 7
d. tell my child not to make a big deal out of missing the party 1 2 3 4 5 6 7
e. encourage my child to express his/her feelings of anger and frustration 1 2 3 4 5 6 7
f. soothe my child and do something fun with him/her to make him/her feel better about missing the party 1 2 3 4 5 6 7

2. If my child falls off his/her bike and breaks it, and then gets upset and cries, I would:

a. remain calm and not let myself get anxious 1 2 3 4 5 6 7
b. comfort my child and try to get him/her to forget about the accident 1 2 3 4 5 6 7
c. tell my child that he/she is over-reacting 1 2 3 4 5 6 7
d. help my child figure out how to get the bike fixed 1 2 3 4 5 6 7
e. tell my child it's OK to cry 1 2 3 4 5 6 7
f. tell my child to stop crying or he/she won't be allowed to ride his/her bike anytime soon 1 2 3 4 5 6 7

3. If my child loses some prized possession and reacts with tears, I would:

a. get upset with him/her for being so careless and then crying about it 1 2 3 4 5 6 7
b. tell my child that he/she is over-reacting 1 2 3 4 5 6 7
c. help my child think of places he/she hasn't looked yet 1 2 3 4 5 6 7
d. distract my child by talking about happy things 1 2 3 4 5 6 7
e. tell him/her it's OK to cry when you feel unhappy 1 2 3 4 5 6 7
f. tell him/her that's what happens when you're not careful 1 2 3 4 5 6 7

4. If my child is afraid of injections and becomes quite shaky and teary while waiting for his/her turn to get a shot, I would:

a. tell him/her to shape up or he/she won't be allowed to do something he/she likes to do (e.g., watch TV) 1 2 3 4 5 6 7
b. encourage my child to talk about his/her fears 1 2 3 4 5 6 7
c. tell my child not to make big deal of the shot 1 2 3 4 5 6 7
d. tell him/her not to embarrass us by crying 1 2 3 4 5 6 7
e. comfort him/her before and after the shot 1 2 3 4 5 6 7
f. talk to my child about ways to make it hurt less (such as relaxing so it won't hurt or taking deep breaths). 1 2 3 4 5 6 7

Response Scale: 1 2 3 4 5 6 7
Very Unlikely Medium Very Likely

---

5. If my child is going over to spend the afternoon at a friend's house and becomes nervous and upset because I can't stay there with him/her, I would:

a. distract my child by talking about all the fun he/she will have with his/her friend 1 2 3 4 5 6 7
b. help my child think of things that he/she could do so that being at the friend's house without me wasn't scary (e.g., take a favorite book or toy with him/her) 1 2 3 4 5 6 7
c. tell my child to quit over-reacting and being a baby 1 2 3 4 5 6 7
d. tell the child that if he/she doesn't stop that he/she won't be allowed to go out anymore 1 2 3 4 5 6 7
e. feel upset and uncomfortable because of my child's reactions 1 2 3 4 5 6 7
f. encourage my child to talk about his/her nervous feelings 1 2 3 4 5 6 7

6. If my child is participating in some group activity with his/her friends and proceeds to make a mistake and then looks embarrassed and on the verge of tears, I would:

a. comfort my child and try to make him/her feel better 1 2 3 4 5 6 7
b. tell my child that he/she is over-reacting 1 2 3 4 5 6 7
c. feel uncomfortable and embarrassed myself 1 2 3 4 5 6 7
d. tell my child to straighten up or we'll go home right away 1 2 3 4 5 6 7
e. encourage my child to talk about his/her feelings of embarrassment 1 2 3 4 5 6 7
f. tell my child that I'll help him/her practice so that he/she can do better next time 1 2 3 4 5 6 7

7. If my child is about to appear in a recital or sports activity and becomes visibly nervous about people watching him/her, I would:

a. help my child think of things that he/she could do to get ready for his/her turn (e.g., to do some warm-ups and not to look at the audience) 1 2 3 4 5 6 7
b. suggest that my child think about something relaxing so that his/her nervousness will go away 1 2 3 4 5 6 7
c. remain calm and not get nervous myself 1 2 3 4 5 6 7
d. tell my child that he/she is being a baby about it 1 2 3 4 5 6 7
e. tell my child that if he/she doesn't calm down, we'll have to leave and go home right away 1 2 3 4 5 6 7
f. encourage my child to talk about his/her nervous feelings 1 2 3 4 5 6 7

8. If my child receives an undesirable birthday gift from a friend and looks obviously disappointed, even annoyed, after opening it in the presence of the friend, I would:

a. encourage my child to express his/her disappointed feelings 1 2 3 4 5 6 7
b. tell my child that the present can be exchanged for something the child wants 1 2 3 4 5 6 7
c. NOT be annoyed with my child for being rude 1 2 3 4 5 6 7
d. tell my child that he/she is over-reacting 1 2 3 4 5 6 7
e. scold my child for being insensitive to the friend's feelings 1 2 3 4 5 6 7
f. try to get my child to feel better by doing something fun 1 2 3 4 5 6 7

Response Scale: 1 2 3 4 5 6 7
Very Unlikely Medium Very Likely

9. If my child is panicky and can't go to sleep after watching a scary TV show, I would:

a. encourage my child to talk about what scared him/her 1 2 3 4 5 6 7
b. get upset with him/her for being silly 1 2 3 4 5 6 7
c. tell my child that he/she is over-reacting 1 2 3 4 5 6 7
d. help my child think of something to do so that he/she can get to sleep (e.g., take a toy to bed, leave the lights on) 1 2 3 4 5 6 7
e. tell him/her to go to bed or he/she won't be allowed to watch any more TV 1 2 3 4 5 6 7
f. do something fun with my child to help him/her forget about what scared him/her 1 2 3 4 5 6 7

10. If my child is at a park and appears on the verge of tears because the other children are mean to him/her and won't let him/her play with them, I would:

a. NOT get upset myself 1 2 3 4 5 6 7
b. tell my child that if he/she starts crying then we'll have to go home right away 1 2 3 4 5 6 7
c. tell my child it's OK to cry when he/she feels bad 1 2 3 4 5 6 7
d. comfort my child and try to get him/her to think about something happy 1 2 3 4 5 6 7
e. help my child think of something else to do 1 2 3 4 5 6 7
f. tell my child that he/she will feel better soon 1 2 3 4 5 6 7

11. If my child is playing with other children and one of them calls him/her names, and my child then begins to tremble and become tearful, I would:

a. tell my child not to make a big deal out of it 1 2 3 4 5 6 7
b. feel upset myself 1 2 3 4 5 6 7
c. tell my child to behave or we'll have to go home right away 1 2 3 4 5 6 7
d. help my child think of constructive things to do when other children tease him/her (e.g., find other things to do) 1 2 3 4 5 6 7
e. comfort him/her and play a game to take his/her mind off the upsetting event 1 2 3 4 5 6 7
f. encourage him/her to talk about how it hurts to be teased 1 2 3 4 5 6 7

12. If my child is shy and scared around strangers and consistently becomes teary and wants to stay in his/her bedroom whenever family friends come to visit, I would:

a. help my child think of things to do that would make meeting my friends less scary (e.g., to take a favorite toy with him/her when meeting my friends) 1 2 3 4 5 6 7
b. tell my child that it is OK to feel nervous 1 2 3 4 5 6 7
c. try to make my child happy by talking about the fun things we can do with our friends 1 2 3 4 5 6 7
d. feel upset and uncomfortable because of my child's reactions 1 2 3 4 5 6 7
e. tell my child that he/she must stay in the living room and visit with our friends 1 2 3 4 5 6 7
f. tell my child that he/she is being a baby 1 2 3 4 5 6 7

DASS21

Name: Date:

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you **over the past week**. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0 Did not apply to me at all
1 Applied to me to some degree, or some of the time
2 Applied to me to a considerable degree or a good part of time
3 Applied to me very much or most of the time

1 (s)	I found it hard to wind down	0	1	2	3
2 (a)	I was aware of dryness of my mouth	0	1	2	3
3 (d)	**I couldn't seem to experience any positive feeling at all**	0	1	2	3
4 (a)	I experienced breathing difficulty (e.g. excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5 (d)	I found it difficult to work up the initiative to do things	0	1	2	3
6 (s)	I tended to over-react to situations	0	1	2	3
7 (a)	I experienced trembling (e.g. in the hands)	0	1	2	3
8 (s)	I felt that I was using a lot of nervous energy	0	1	2	3
9 (a)	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
10 (d)	I felt that I had nothing to look forward to	0	1	2	3
11 (s)	I found myself getting agitated	0	1	2	3
12 (s)	I found it difficult to relax	0	1	2	3
13 (d)	I felt down-hearted and blue	0	1	2	3
14 (s)	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15 (a)	I felt I was close to panic	0	1	2	3
16 (d)	I was unable to become enthusiastic about anything	0	1	2	3
17 (d)	**I felt I wasn't worth much as a person**	0	1	2	3
18 (s)	I felt that I was rather touchy	0	1	2	3
19 (a)	I was aware of the action of my heart in the absence of physical exertion (e.g. sense of heart rate increase, heart missing a beat)	0	1	2	3
20 (a)	I felt scared without any good reason	0	1	2	3
21 (d)	I felt that life was meaningless	0	1	2	3

LIFE EVENTS CHECKLIST (LEC)

Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check one or more of the boxes to the right to indicate that: (a) it *happened to you* personally, (b) you *witnessed it* happen to someone else, (c) you *learned about it* happening to someone close to you, (d) you're *not sure* if it fits, or (e) it *doesn't apply* to you.

Be sure to consider your *entire life* (growing up as well as adulthood) as you go through the list of events.

Event	Happened to me	Witnessed it	Learned about it	Not Sure	Doesn't apply
1. Natural disaster (for example, flood, hurricane, tornado, earthquake)					
2. Fire or explosion					
3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash)					
4. Serious accident at work, home, or during recreational activity					
5. Exposure to toxic substance (for example, dangerous chemicals, radiation)					
6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)					
7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)					
8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)					
9. Other unwanted or uncomfortable sexual experience					
10. Combat or exposure to a war-zone (in the military or as a civilian)					
11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)					
12. Life-threatening illness or injury					
13. Severe human suffering					
14. Sudden, violent death (for example, homicide, suicide)					
15. Sudden, unexpected death of someone close to you					
16. Serious injury, harm, or death you caused to someone else					
17. Any other very stressful event or experience					

Blake, Weathers, Nagy, Kaloupek, Charney, & Keane, 1995 1

Emotion regulation Questionnaire (ERQ)
Gross and John
9/03

The Emotion Regulation Questionnaire is designed to assess individual differences in the habitual use of two emotion regulation strategies: cognitive reappraisal and expressive suppression.

Citation
Gross J J and John O P (2003) Individual differences in two emotion regulation processes: Implications for affect, relationships, and well-being. *Journal of Personality and Social Psychology*, 85, 348-362.

Instructions and Items
We would like to ask you some questions about your emotional life, in particular, how you control (that is, regulate and manage) your emotions. The questions below involve two distinct aspects of your emotional life. One is your **emotional experience**, or what you feel like inside. The other is your **emotional expression**, or how you show your emotions in the way you talk, gesture, or behave. Although some of the following questions may seem similar to one another, they differ in important ways. For each item, please answer using the following scale:

1	2	3	4	5	6	7
Strongly disagree			Neutral			Strongly agree

1. ☐ When I want to feel more *positive* emotion (such as joy or amusement), I *change what I'm thinking about.*
2. ☐ I keep my emotions to myself.
3. ☐ When I want to feel less *negative* emotion (such as sadness or anger), *I change what I'm thinking about.*
4. ☐ When I am feeling *positive* emotions, I am careful not to express them.
5. ☐ When I'm faced with a stressful situation, I make myself *think about it* in a way that helps me stay calm.
6. ☐ I control my emotions by *not expressing them*.
7. ☐ When I want to feel more *positive* emotion, I *change the way I'm thinking* about the situation.
8. ☐ I control my emotions by changing the way I think about the situation I'm in.
9. ☐ When I am feeling *negative* emotions, I make sure not to express them.
10. ☐ When I want to feel less *negative* emotion, I *change the way I'm thinking* about the situation.

Note
Do not change item order, as items 1 and 3 at the beginning of the questionnaire define the terms "positive emotion" and "negative emotion".

Scoring (no reversals)
Reappraisal Items: 1, 3, 5, 7, 8, 10; Suppression Items: 2, 4, 6, 9.

Reference: Gross J J and John O P (2003). Individual differences in two emotion regulation processes: Implications for affect, relationships, and well-being. *Journal of Personality and Social Psychology*, 85, 348-362.

Appendix 3j: Instructions for authors (*Child Abuse and Neglect)*

LENGTH AND STYLE OF MANUSCRIPTS

Full-length manuscripts should not exceed 35 pages total (including abstract, text, references, tables, and figures), double spaced with margins of at least 1 inch on all sides and a standard font (e.g., Times New Roman) of 12 points (no smaller).

Instructions on preparing tables, figures, references, metrics, and abstracts appear in the Publication Manual of the American Psychological Association (6th edition).

ARTICLE STRUCTURE

Subdivision

Divide your article into clearly defined sections. Three levels of headings are permitted. Level one and level two headings should appear on its own separate line; level three headings should include punctuation and run in with the first line of the paragraph.

Introduction

State the objectives of the work and provide an adequate background, avoiding a detailed literature survey or a summary of the results.

Abstract

Abstracts should follow a structured format of no more than 250 words including the following sections: Background, Objective, Participants and Setting, Methods, Results (giving specific effect sizes and their statistical significance), and Conclusions.

KEYWORDS

Immediately after the abstract, provide a maximum of 6 keywords, using American spelling and avoiding general and plural terms and multiple concepts (avoid, for example, 'and', 'of'). Be sparing with abbreviations: only abbreviations firmly established in the field may be eligible. These keywords will be used for indexing purposes.

Figure captions

Ensure that each illustration has a caption. Supply captions separately, not attached to the figure. A caption should comprise a brief title (NOT on the figure itself) and a description of the illustration. Keep text in the illustrations themselves to a minimum but explain all symbols and abbreviations used.

TABLES

Please submit tables as editable text and not as images. Tables can be placed either next to the relevant text in the article, or on separate page(s) at the end. Number tables consecutively in accordance with their appearance in the text and place any table notes below the table body. Be

sparing in the use of tables and ensure that the data presented in them do not duplicate results described elsewhere in the article. Please avoid using vertical rules and shading in table cells.

REFERENCES

Citation in text

Please ensure that every reference cited in the text is also present in the reference list (and vice versa). Any references cited in the abstract must be given in full. Unpublished results and personal communications are not recommended in the reference list, but may be mentioned in the text. If these references are included in the reference list they should follow the standard reference style of the journal and should include a substitution of the publication date with either 'Unpublished results' or 'Personal communication'. Citation of a reference as 'in press' implies that the item has been accepted for publication.

Web references

As a minimum, the full URL should be given and the date when the reference was last accessed. Any further information, if known (DOI, author names, dates, reference to a source publication, etc.), should also be given. Web references can be listed separately (e.g., after the reference list) under a different heading if desired, or can be included in the reference list.

Reference style

Text: Citations in the text should follow the referencing style used by the American Psychological Association (view the APA Style Guide). You are referred to the Publication Manual of the American Psychological Association, Sixth Edition, ISBN 978-1-4338-0561-5.